The University of Alberta

The Ethics of Elective Caesarean Delivery

By

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Abstract

Current analyses of elective caesarean delivery conclude that physicians ought not to offer the procedure to pregnant women as a matter of course, and they ought to discourage requests. These analyses assume a primacy of considerations of beneficence over those of respect for autonomy. Procedures in cosmetic surgery have gained quiet moral acceptance through autonomy-based discourse. Some relevant similarities between elective caesarean delivery and surgical chest enhancement suggest that the two procedures reasonably merit the *same* moral evaluation.

These differing moral evaluations are justified by their underlying moral commitments which prioritize one principle over another. Pellegrino and Thomasma argue for the priority of beneficence, while Veatch and Engelhardt argue for the priority of respect for autonomy. Beauchamp and Childress reject prioritization altogether, in favour of evaluations that rely on contextual details about the particular case. An analysis of elective caesarean using this method delivery suggests that an autonomy-based approach to this procedure is *more* justified than a beneficence-based one.

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Introduction

The increasingly common occurrences of requests for, and the performance of elective caesarean delivery is generating controversy among physicians and ethicists, particularly those working in the field of obstetrics and gynaecology. This issue rekindles on-going disagreements about the appropriate domain and nature of medical practice, the appropriate role of physicians, conceptions of beneficence versus those of respect for autonomy[1], patient's rights, and physician autonomy, to name a few. Although they do not avoid these issues, the initial questions posed and responded to in the ethics literature on elective caesarean delivery are practical ones. They are: 1) ought these elective caesarean sections to be offered to all pregnant mothers as a matter of course? And, assuming there has been no decision *to* offer them, 2) how ought to a physician[2] respond to a request for one?

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[1] There is a distinction between the terms 'autonomy' and 'respect for autonomy'. The latter refers to an individual and fundamental notion of self-determination held in varying degrees by all individuals. The former identifies a concept more specific to medical ethics whereby, within the relationship between physician and patient, *that* the autonomy of the patient is acknowledged and responded to in some way is important. [See Beauchamp and Childress's distinction]

[2] I will use the term 'physician' to refer to a range of health care professionals as is appropriate to the particular context.

The commentary in current bioethics literature responding to these questions occurs largely within the well-established deontological framework known as principlism. Principles of beneficence, respect for autonomy, and to a lesser degree, justice, form the scaffold around which ethical analysis of this matter takes place. Using this moral framework, nearly all of the current articles about the ethics of elective caesarean delivery argue that, out of considerations of beneficence, the duty to minimize medical harm and maximize medical benefit – elective caesarean sections ought not to be generally offered to pregnant women and individual physicians ought to proceed cautiously when responding to their requests. Professional organizations in the field of obstetrics and gynaecology express a similar position citing considerations of beneficence as the decisive element in their moral evaluation. This assumed primacy of beneficence is neither necessary nor inherent to the analysis of this issue, however. Principles of respect for autonomy and beneficence often appear to be inextricably at odds with one another in moral dilemmas precisely because there are, prima facie, equally good arguments for the prioritization of one over the other. Not only is it reasonable, then, to consider the moral dimensions of elective caesarean delivery with presumptions of primacy of respect for autonomy, but this analysis also seems necessary to fill a conceptual gap in the literature.

In this thesis I argue that an autonomy-based approach to moral evaluations of elective caesarean delivery is at least as, if not more justified than the beneficence-based approach expressed in current literature. The possibility of, and conclusions derived from such an approach have, thus far, been ignored by the literature creating a gap in the analysis of this issue. Having argued for the rationality of this approach I make an initial attempt to fill this gap by providing a moral evaluation of delivery by elective caesarean with assumptions of the primacy of respect for autonomy.

In Chapter 1, I introduce the issue, outline the dominant position expressed in the literature and by the professional organizations, and then describe a moral framework which discusses its inhering principles in terms of individual interests. This moral framework is useful in the analysis because it provides a conceptual tool for dissecting the arguments and underlying assumptions of positions presented on elective caesarean sections so far. It is particularly useful because the ethicists who present this account, Frank Chervenak and Laurence McCullough, have also published a number of articles on the morality of elective caesarean delivery directly.

Having established the tenor of the current analysis on the issue, I delve more deeply into the moral theory of medical ethics to outline two philosophical camps; one composed of theorists who defend the primacy of beneficence over respect for autonomy, and the other composed of those who

do the reverse. The purpose of this discussion is to demonstrate that assumptions of one principle over another stem from basic philosophical arguments, and that neither account has successfully refuted the other. In light of the philosophical support for both, there is as much reason to prioritize respect for autonomy over beneficence as to do it the other way around.

In Chapter 2 I address and set aside considerations of the foetus. A historical legacy of issues surrounding duties towards the foetus and the existence of controversial and (as a result) unresolved issues surrounding potential duties towards foetuses, I suspect, are responsible for the absence of any autonomy-based account of elective caesarean sections to date. Considerations of autonomy become more complicated when there is more than one agent to consider, particularly if, as is the case with gestating foetuses, the internal desires and wishes of one agent cannot known and it is solely within the power of the other agent (the pregnant woman) to ensure that these externally predicted interests are met. With specific reference to elective caesarean sections, I argue that even if we ascribe a full complement of rights to a gestating foetus, the medical risks of the procedure for the gestating foetus are comparable to those presented by vaginal delivery, so moral considerations of the foetus do not contribute one side of the argument or the other and so can be set aside.

Chapter 3 discusses practices in medicine whose ongoing acceptance and availability are rationalized morally through assumptions of primacy of autonomy. Such procedures include abortion, sterilization, fertilization treatment, and cosmetic surgery. Here, although I do not intend to argue for the ultimate primacy of respect for autonomy over considerations of beneficence in all cases, I illustrate the rationale behind an autonomy-based approach to elective caesarean delivery by drawing an analogy between it and cosmetic surgery procedures

Chapter 4 returns the focus to the theoretical underpinnings of philosophical commitments of either beneficence or respect for autonomy and brings them together with the dominant commentary to highlight where presumptions of beneficence are reflected in their account and to highlight how they affect their overall conclusions. I then articulate an evaluation of elective caesarean delivery using presumptions of autonomy. Beauchamp and Childress's arguments against absolute prioritization of principles in addition to their views regarding the importance of context in our moral evaluations creates conceptual space for further arguments towards the view that, not only is an autonomy-based approach to elective caesarean delivery reasonable, so uncovering a gap in the analysis that needs to be filled, but also that it might actually be more appropriate than the beneficence-based approaches dominating the literature so far.

Chapter 1

Elective Caesarean Delivery and Moral Theory

1.1 Introduction

The issue of elective caesarean delivery is addressed in the literature by a small yet prolific group of commentators who find the procedure to be morally problematic and believe that it ought not to be a part of normal obstetrical and gynecological practice. This chapter clarifies the nature of the controversy by casting the moral question on two separate levels and analyzes elective caesarean delivery using an interests-based moral framework.

I begin by describing the dominant moral evaluation of elective caesarean delivery reflected both in the bioethics literature and the position papers of various professional organizations in the field of obstetrics and gynaecology. Following is a summary of the most recent research on the maternal risks presented by caesarean delivery. I then outline a version of a principles-based framework described by Laurence McCullough and Frank

Chervenak in their book *Ethics in Obstetrics and Gynecology*[3]. I engage with this particular account of principlism in part because these authors have produced the majority of the literature on the moral analysis of elective caesarean sections to date. Their framework discusses the principles of respect for autonomy, and beneficence in terms of patients' interests, providing a more sophisticated ontology with which to flesh out the main arguments surrounding elective caesarean delivery.

After identifying what I take to be a presumption of the primacy of beneficence-based reasoning in the dominant evaluation of elective caesarean delivery, I introduce and discuss fundamental arguments in medical ethics theory for the moral primacy of respect for autonomy versus that of beneficence, to see if this presumption is justified.

1.2 The Dominant Position on Elective Caesarean Delivery

1.2.1 Locating the questions

Current discussions in the bioethics literature address two general questions: should elective caesarean delivery be offered to pregnant women as a delivery option and, if not, ought physicians to comply when a patient requests one?

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[3] McCullough, LB, Chervenak FA, Ethics in Obstetrics and Gynecology (New York: Oxford University Press) 1984.

The first question deals directly with the duties of the medical profession; there is no particular patient to consider, and considerations of appropriate professional conduct and allocation of resources are salient. It might seem that this question could apply at both the professional and the individual level, after all, when a physician and a patient are in a room together it is theoretically possible for the physician to offer the patient a range of procedures. When posed at the professional level, however, the question is really whether elective caesarean sections are something that any physician should mention to any normal healthy pregnant patient *at all*. This is an issue at the professional level because decisions regarding what is reasonably included in this initial discussion of treatment options is not, by and large, decided uniquely by each individual physician, but occur more collectively through professional institutions. Some background on informed consent law might helpfully illustrate.

When a patient presents herself to the physician with a complaint, the physician diagnoses the condition and discusses a number of treatment options, usually recommending the ones he considers most beneficial to the patient. Medical malpractice suits relating to issues of informed consent have set precedents that, in part, contribute to a standard of disclosure that outlines the kinds of information legally required to be discussed with a patient to achieve his or her informed consent. Such information includes the

patient's prognosis if the condition is left untreated, the range of treatments available for this condition, the risks and side-effects of these treatments, and the physician's recommended course of action.[4] A physician who fails to discuss a treatment alternative that has been deemed reasonable by the profession could be accused of medical incompetence.

Many standards have been offered to determine the level and content of disclosed information required for a patient to be fully informed. Two are particularly useful. The first, known as the 'medical professional standard' evaluates the adequacy of the information presented to a patient based on what the "reasonable medical profession practicing in that specialty of the professional in question"[5] would disclose. This standard has been rejected by the Supreme Court of Canada in favour of disclosure requirements that take into account the patient's perspective.[6]

A second standard, known as the 'modified objective persons' standard differs from the 'medical professional standard' because it takes account of the patient's perspective rather than that of the profession. Further, it encompasses a broad notion of "material" risk where "material" not only refers to the risks of the surgery itself, but also "the risks of surgery posed to the patient's ability to live his life by a reasonable criteria, including

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[4] Dickens, BM, "Informed Consent", printed in ed. Jocelyn Downie, Timothy Caufield, *Canadian Law and Health Policy*, (Vancouver: Butterworths, 1999), 129.
[5] Dickens, BM, "Informed Consent", printed in ed. Jocelyn Downie, Timothy Caufield, *Canadian Law and Health Policy*, (Vancouver: Butterworths, 1999), 121.
[6] *Hopp v. Lepp*, (1980), 112 D.L.R. (3d) 67 (S.C.C.), 80.

his ability to earn a livelihood, provide for his family and afford his children opportunities for education."[7] By this standard, physicians are required to actively determine the circumstances of their patients' lives to anticipate kinds of information that would particularly relevant to their decision-making process.

The question of whether or not elective caesarean delivery ought to be offered is really a question about whether or not it ought to be included within the array of treatment alternatives as required by a professional standard of disclosure. The 'medical professional standard' maps illustratively on to the concept of decision-making at the professional level because in neither case are the patient's individual needs taken into consideration.

This 'medical professional standard' is similar to the standards that dictate what procedures are offered for particular medical conditions because both are professionally self-referential. The process whereby physicians arrive at an understanding of what is appropriate to offer a patient is not, in general, mediated explicitly by a professional organization or ruling body, but is arrived at more organically through the establishment of norms within the profession. Similarly, the 'medical professional standard' of disclosure requires that the physician disclose information to her patient that the

[7] Dickens, BM, 1999, pp. 120.

average reasonable physician in her position would disclose. If challenged in court, other physicians would be brought in as expert witnesses to represent other 'reasonable physicians in a similar position' and give content to this standard of conduct. The content of the current professional standard for the range of appropriate treatments to offer to a patient is determined in a professionally self-referential fashion as well. A particular procedure can (and ought to) be offered if it is what the average physician in that position would offer. When a physician is challenged about whether or not they ought to have offered a procedure that they failed to, other physicians to testify in order to determine if this is in line with what the average physician in a similar position would have done.

An exception to the unmediated nature of the development of standards for offering procedures is presented in the recent "Guidelines for Vaginal Birth after Previous Caesarean Birth"[8] published by the Society of Obstetricians and Gynaecologists of Canada (SOGC) which specifically stipulates that women who have had one previous delivery via a transverse low-segment Caesarean section should, provided there are no contraindications, be offered a trial of labour for their second birth.

[8] Society of Obstetricians and Gynaecologists of Canada, Clinical Practice Guidelines, No. 155 (Replaces guideline No. 147) February, 2005. Available at: http://www.sogc.org/sogcnet/sogc_docs/common/guide/documents/JOGC-feb-05-martel-CPG.pdf

The second question regarding how a physician ought to respond when faced with a request for elective caesarean delivery refers to an exchange between a physician and an individual patient who has interests, values, and beliefs that the physician (according to the principle of respect for autonomy) has a duty to respect. The nature of this exchange is reflected in the underlying values of the 'modified objective standard' of disclosure outlined above. In both cases, details of the individual patient's lives are pertinent to the interaction. This question assumes that there is no professional agreement that an elective caesarean section should be offered to every pregnant patient; either it has been decided against, or the matter is still under debate. In either case, the physician has not planned to initiate discussion with her patient regarding delivery via elective caesarean.

1.2.2 The Position taken by Professional Organizations

The American College of Obstetricians and Gynecologists (ACOG) argues that physicians should not initiate discussion, suggest or offer elective caesarean delivery because it has not yet conclusively been shown to be safe[9]. The burden of proof, they contend, lies with those who support making the procedure available; these supporters need to show that the procedure presents fewer medical risks and more benefits than vaginal delivery. The current lack of evidence demonstrating the increased benefit of elective

[9] ACOG News Release, October 31, 2003 – New ACOG Opinion Addresses Elective Cesarean Controversy.

caesarean delivery over vaginal delivery precludes ACOG from determining whether or not, using their criteria of medical benefit, it is morally permissible to make elective caesareans available.

ACOG takes a more neutral position regarding physician response to patient requests for the procedure, giving greater consideration to patient autonomy: "if the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than does vaginal birth, then he or she is ethically justified in performing a cesarean delivery."[10] In the case where the physician feels that an elective ceasarean would be detrimental to the health of the woman and her foetus then she can refuse to perform the procedure and offer to refer the woman to another physician.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) opposes offering elective caesarean sections from considerations of beneficence, justice and the value of the natural over medical or technical processes. [11] They too cite a lack of evidence for the safety and increased benefit of elective caesarean delivery over vaginal delivery as the reason for their decision implying that without proof of medical benefit - a requirement for beneficent action - they won't consider other arguments for supporting

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[10] *Ibid.*

[11] SOGC – Media Advisory, Wednesday March, 10, 2004. Note that this is a press release not a formal policy statement.

the procedure. Consideration of principles of justice raises the concern that supporting the regular performance of elective caesarean sections would unjustly remove resources from others in need in a system where medical resources are already overextended. Finally, they worry that supporting the performance of this procedure would precipitate the transformation of the natural process of childbirth into a surgical one.

The International Federation of Gynecology and Obstetrics (FIGO) makes no distinction between offering and responding to patient requests for elective caesarean sections. They conclude that performing an elective caesarean delivery without medical indication is ethically unjustified.[12] They take a similar position to SOGC, citing the duty of physicians to allocate medical resources to those procedures that provide a "net benefit to health", concluding that "physicians are not obligated to perform an intervention for which there is no medical advantage."[13] FIGO also expresses concerns about the lack of conclusive evidence for short and long-term outcomes of elective caesarean delivery and so they do not support making the procedure available.

ACOG, SOGC, and FIGO ground their position regarding elective caesarean delivery in arguments of beneficence, justice, and appeals to the

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[12] International Federation of Gynecology and Obstetrics, 1999, FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, *International Journal of Gynecology & Obstetrics*, 64, 317-322.
[13] *Ibid.*, pp. 321.

superiority of naturalness over medical procedures. With the exception of ACOG (and then only in a brief Letter to the Editor[14]) there is little acknowledgement of considerations of respect for patient autonomy contributing to these moral evaluations.

1.2.3 Current Bioethics literature

The most common position in the current bioethics literature on elective caesarean delivery echoes that taken by the professional organizations. Frank McCullough and Laurence Chervenak provide a comprehensive outline of this position which accounts well for the arguments used by others who also take this view so I will discuss their work in this section.

In response to the first question, McCullough and Chervenak et al. conclude that, given duties of beneficence, the obligation to maximize clinical benefit and minimize clinical harm, *offering* an elective caesarean delivery is ethically unjustifiable.[15,16,17] Their argument begins with the premise that the principle of beneficence requires physicians to maximize clinical benefit and minimize clinical harm to the patient. This applies in many circumstances, but importantly so when a physician selects an array of treatment options to

[14] Letter to the Editor, The Washington Post, February 14, 2004.
[15] Minkoff, H, Chervenak, FA, "Elective Primary Cesarean Delivery", *New England Journal of Medicine* 2003, 348; 10, 946 – 950.
[16] Minkoff, H, Powderly, KR, Chervenak, F, McCullough, LB, "Ethical Dimensions of Elective Primary Cesarean Delivery", *Obstetrics and Gynecology* 2004, 103(2): 387 – 392.
[17] Sharma, G, Chervenak, FA, McCullough, LB, Minkoff, H, "Ethical Considerations in Elective Cesarean Delivery", *Clinical Obstetrics and Gynecology* 2004, 47(2): 404 – 408.

offer a patient.[18] They also contend, although this premise is becoming increasingly tenuous, that elective caesarean delivery presents increased risks and uncertainty for the patient compared to those presented by vaginal delivery. As a result, the physician is not morally permitted to offer or recommend an elective cesarean as a mode of delivery because to do so would be to violate the principle of beneficence.[19]

This conclusion places the burden of proof on the proponents of elective caesarean delivery to show that it is more effective and safer than established treatments or interventions. Since there is no hard evidence of equal or increased benefit, the argument goes, minimally, there is no obligation to offer or recommend elective caesarean delivery as a matter of course.

In deciding what the appropriate response to a *request* for elective caesarean delivery may be, respect for patient autonomy is given a little more consideration. However, the argument that individual autonomy requires physicians to acquiesce when a patient requests an elective caesarean is rejected by McCullough and Chervenak on the grounds that patients do not have positive rights to resources that have not been offered to them.[20] On their account patient autonomy is introduced to the clinical environment via

[18] Minkoff et al., 2004, pp. 390.
[19] Minkoff et al., 2004, pp. 389.
[20] *Ibid.*, pp. 390.

the informed consent process and to allow for positive rights within this process "turns the entire informed consent process on its head and turns the physician into a mere technician."[21] Patient autonomy, then, ensures only the patient's negative right to refuse treatment.

Considerations of the foetus, according to McCullough and Chervenak's argument, also narrow the scope of patient autonomy. They bring up cosmetic surgery as an analogous procedure where individuals unquestioningly decide to assume all manner of medical risk: "Procedures such as liposuction or breast augmentation put patients at some risk and often prevent no medical morbidity... Of course, with such elective procedures the patient is assuming whatever risks are present for herself. With elective cesarean delivery, the pregnant woman is pursuing benefits and assuming risks not only for herself, but also for the fetal patient."[22]

Having said this, McCullough and Chervenak do allow for the physician to provide elective caesarean delivery to the insistent patient provided she is fully informed of the risks although they strongly encourage physicians to pressure women against having the procedure. McCullough and Chervenak recommend persuading the patient to change her mind[23] or, at the very least, asking her to reconsider her decision[24]. In cases where it is

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[21] *Ibid.*
[22] *Ibid.*
[23] Paterson-Brown, S, et al., 1998, pp.464.
[24] Sharma et al., 2004, pp. 407; Minkoff et al, 2004, pp.390.

clear that the woman is certain of her decision and that her concerns cannot be addressed in other ways, they suggest that after carefully discussing all available and relevant information with her, the physician either perform the elective caesarean section or, if the physician has moral objections to the procedure, direct the woman to a physician who is willing.

McCullough and Chervenak's ethical analysis of issues presented by elective caesarean delivery points to some underlying assumptions about the nature and ordering of moral principles. For example, they confine considerations of respect for patient autonomy to the realm of informed consent which is necessarily limited by considerations of beneficence, implying a prioritization of principles. To flesh out the details of these arguments against elective caesarean delivery I turn to McCullough and Chervenak's moral framework for obstetrics and gynaecology.

1.3 Theory in Medical Ethics – Interests-based

1.3.1 McCullough and Chervenak Interests- based Bioethics Framework

McCullough and Chervenak construct a moral framework that expressly acknowledges and realizes what they see as the fundamental role of any framework for bioethics, namely, to supply "the origin and meaning of the obligation to protect and promote the patient's interests."[25] They describe

[25] *Ibid.*, pp. 10.

a three-dimensional framework that accounts for a range of these interests. The first dimension describes and distinguishes between interests that can be identified from an internal vantage point versus those that can be described from an external one. For example, we might be able to identify from an external perspective, a human being's interest in food and shelter in virtue of being human, however, only from some internal vantage point can particular spiritual values or beliefs be identified. In a medical context, it is within the epistemic capabilities of physicians to assume the existence of a subset of a patient's interests without necessarily having to confirm them with the patient, while interests identified from an internal perspective, experienced and identified first hand by the individual, can only be accessed through some form of direct consultation. This dimension acknowledges the simultaneous existence of those interests that can reasonably be predicted by an external observer and those interests where the true and ongoing nature of which can only be known by the agent themselves and so must be expressed for them to be recognized by others. This dimension of internally versus externally identifiable interests, argue McCullough and Chervenak, also maps out the distinct domains of application for principles of beneficence and respect for autonomy: the former applies to the promotion of interests that are identifiable by an outside observer and the latter, to interests identifiable from the internal perspective.

The second dimension describes a range within the externally identifiable interests that relies on the sociological idea that most people take on various social roles at different times that furnish them with particular interests that inhere not in themselves as individuals, but in the particular role they play at a given time. Variation in this dimension occurs to the degree that individuals take on a specific role and the degree to which the role is amenable to carrying specific interests with it. In cases where an individual adopts specific and recognizable social roles and fulfills that role fully they are said to have "social–role interests"[26]. According to McCullough and Chervenak, such social roles may include those of a parent, accountant, citizen of a democracy, and medical patient. For example, one element of the social role of a parent is "that their children mature into independent adults."[27] Parents (who necessarily participate in the same social role) share common interests in maintaining their children's health, protecting them from harm, and fostering the continuous development of their social and intellectual skills.

Social-role interests are informed and delimited by two factors: first, those outcomes that have been reasonably shown, historically and across

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[26] *Ibid,* pp. 28; M&C identify a second externally identifiably category of interests they call "Needs-Based Interests" (26-27). These are said to be interests that are identifiable based on a universal conception of the good. They refrain from pursuing this line because they do not wish to formulate or defend some conception of the good nor do they see a notion of 'the good' as necessary for their project. For this reason, I leave it out of this exposition.
[27] *Ibid,* pp. 28.

cultures, to be among human goods (although these do not represent an account of *the* human good); and second the limits of the social institution connected to a particular social role. Those goods relevant to the social-role of *patient* have emerged historically and culturally and include the preservation of health[28], prolongation of life, the cure of disease, and the minimization of unnecessary pain and suffering. In accordance with the second factor, the character and range of social-role interests of the patient are by definition, limited by the capabilities of medicine[29]. Epistemically, these interests can be broadly construed and are held by an individual in virtue of his or her position. The holding of these externally identifiable social-role interests can be extended to other individuals who fill the same particular role. This social-role construct is meant to capture and account for many individuals "with all of their different concrete values and preferences."[30]

The third dimension described by McCullough and Chervenak encompasses those interests that are identified from the internal perspective only. This dimension accounts for a variation in interests caused by differences in "intellectual discipline and rigor"[31] applied in the formation of a particular interest and, in doing so, separates McCullough and Chervenak's notions of "subjective" and "deliberative interests". Subjective interests need

[28] I recognize difficulties in strictly defining 'health' but wish to bracket those at this point.
[29] McCullough and Chervenak acknowledge the implications that this obligation varies with the availability of technology and expertise.
[30] *Ibid.*, pp. 28.
[31] *Ibid.*, pp. 31.

not be well reflected upon and stem from an individual's particular and presently held values and beliefs "on the basis of which that person chooses to have a stake in an "issue" or outcome of events"[32]. These values are not constrained and can be derived from experiences and beliefs that are unrelated to medical goods.

Deliberative interests, on the other hand, are determined on the basis of values arrived at through active and critical thought and consideration of information relevant to an individual's present circumstance and prospects. The formation of beliefs and values that generate deliberative interests first requires that the relevant information be available for consideration. It also requires a cognitive ability to identify, understand, and critically evaluate information relevant to a specific event or choice.

In summary, McCullough and Chervenak's framework identifies three variables that affect the character of held interests, and in doing so, identifies three kinds of interests that play a role in medical ethics: (a) Social-Role interests, (2) Subjective Interests, and (3) Deliberative Interests. These interests and their underlying beliefs and values inform one another and overlap to a certain degree.[33] These categories are not intended to represent *all* interests any one patient may have, however, articulating these interests

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[32] *Ibid.*, pp. 30.

[33] For example, the physicians' beneficence-based advice for treatment (based on social-role interests on the patient) often play a role in the development of patients' deliberative interests.

establishes the conditions for the recognition and acknowledgment of the many values and interests inevitably taken by an individual into a medical environment.[34] One of the tasks of medical ethics, then, is to determine if one interest or kind of interest is superior to and ought to be weighted more heavily than another, and if so, when this weighting is pertinent.

1.3.2 Beneficence

Duties of beneficence require that physicians maximize clinical benefits while minimizing clinical harms. Under McCullough and Chervenak's conception, the duties of beneficence obligate physicians *"to protect and promote the social-role interests of the patient."*[original italics][35]

In the context of medical ethics, individuals seeking a medical procedure take on the social role of 'patient'. Given the nature of social-role interests, physicians are capable of identifying them. Not only are they able to do so, but they are obliged to act to promote those interests held by the individual in virtue of being a patient. Under this framework, a pregnant woman is assumed to be a patient and as such, shares the social-role interests held by other patients.[36]

Again, these social-role interests are determined by the competency of medicine: a physician, under the principle of beneficence is only obliged to

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[34] McCullough, FA, and Chervenak, LB, 1994, pp. 32.
[35] *Ibid.* pp. 37.
[36] *Ibid.*, pp. 113; Further discussion is warranted as to the status of the foetus in the interests framework. For the time being, I'll bracket this issue, and return to it in Chapter 2.

promote those needs that her skills and the available medical resources and technology can reasonably be expected to promote. Social-role interests in medicine are identified generally as those related to the prevention of premature or unnecessary death, the preservation of health, prolongation of life, minimization of pain and suffering, and the curing of disease.[37] The duty of beneficence, as characterized by McCullough and Chervenak, does not, nor should it address or respond to the subjective or deliberative interests of an individual.

Consistent with this account of social-role interests McCullough and Chervenak state explicitly that, under considerations of beneficence patients' interests are not a matter of subjective or personal evaluation on the part of the physician, rather they are a matter of "rigorous clinical judgment"[38]. Considerations of risk and the weighing of medical harms and benefits play a large role in this assessment of beneficence-based obligations because they contribute significantly to the effective promotion of social-role interests of a patient. Under this conception of beneficence, statistics on morbidity and mortality for a particular procedure or treatment are relevant in determining the range of beneficent actions as they relate directly to the social-role interests of the patient to avoid harm, or premature and unnecessary death.

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[37] *Ibid.*, pp. 37.

[38] Chervenak, FA, McCullough, JB. 1993. What is Obstetric Ethics? *Clinical Obstetrics and Gynecology*, Vol. 35, No. 4, pp. 710.

This judgment is used to ensure that a balance of medical goods over harm to the patient is realized as a consequence of a physician's decisions and actions.

1.3.3 Respect for Autonomy

While considerations of beneficence apply to the domain of externally identifiable interests, considerations of respect for autonomy apply to those interests that are internal to the agent - subjective and deliberative interests[39]. Unlike considerations of beneficence which represent the clinical perspective, the principle of respect for autonomy acknowledges the patient's perspective whereby examining the patient's values and beliefs, the physician considers information about clinical and surgical options and decides which options are more or less likely to promote these held values.[40]

Subjective and deliberative interests stem from beliefs and values that lie beyond considerations of medical health. They may involve religious convictions, moral principles, beliefs about quality of life, and considerations of life planning (for example the number of children an individual would like to bear). The principle of respect for autonomy obliges physicians to accept and respect these values and beliefs and their implications for treatment.[41] Autonomy-based clinical judgment is inherently variable as each judgment is made in reference to the values and beliefs of a particular patient. It might

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[39] McCullough, LB, and Chervenak, FA, 1994, pp. 55.
[40] Laurence B. McCullough, James W. Jones, Baruch A. Brody. *Surgical Ethics* (New York: Oxford University Press) 1998, pp. 7.
[41] Chervenak, FA, McCullough, LB. 1993, pp.710.

also vary with time either as individuals develop different subjective interests, as the basis for decision making changes subjective interests to deliberative ones, or as their deliberative interests change over time with the acquisition of new information or insight into the circumstance.

Considerations of beneficence may conflict with those of respect for autonomy when beneficence-based judgments are inconsistent with a patient's values and beliefs. Such is the case when a patient refuses life-saving treatment. While receiving life-saving treatment would promote a patient's social-role interests (by preventing premature or unnecessary death), it may ignore or violate his or her subjective or deliberative interests (if for example the patient values dying with dignity, or wishes to avoid life in a state of permanent bed-ridden paralysis). While, on this account, physicians have the authority, and, in such cases, ought to make a recommendation that serves the patient's social-role interests they do not have the authority to act unilaterally on this clinical judgment.[42] The principle of respect for autonomy limits this authority of "rigorous clinical judgment", requiring physicians to determine, respect, and promote the subjective and deliberative interests of their patients. Although some attempts have been made to determine a lexical ordering of these principles[43], in this framework McCullough and Chervenak do not explicitly argue for the

[42] McCullough, LB et al. *Surgical Ethics*, 1998, pp. 18.
[43] See Robert M. Veatch, *A Theory of Medical Ethics*.

primacy of one principle over the other. This is largely due to the variable nature of each of the principles. It cannot be assumed that one ought to consistently trump the other.[44]

1.3.4 The Implications of the Dominant Position[45] in terms of Interests

The positions on elective caesarean delivery outlined in the bioethics literature and by professional organizations in obstetrics and gynaecology are similar enough for the two positions to be characterized as one. The general thrust of the argument is that elective caesarean delivery ought not to be offered because there is no evidence that it is beneficial to the patient – i.e. because it appears to violate the principle of beneficence. For similar reasons, one ought to avoid acquiescing when faced with a request.

In terms of McCullough and Chervenak's interest-based framework for bioethics, the underlying concern expressed in the dominant position is almost entirely for patients' social-role interests *as patients*, with little consideration for other internally identifiable interests. Although these subjective or deliberative interests are acknowledged through brief mentions of respect for patient autonomy, these are done so secondarily and these interests are only taken into consideration reluctantly, apparently because to consider patient autonomy entails an undesirable violation of the principle of

[44] McCullough, LB, and Chervenak, FA, 1994, pp. 58.
[45] When I mention the "dominant evaluation" or "dominant position" on ECS, I am referring to this widely accepted account.

beneficence. No comparable duress is detectable with the implicit subjugation of considerations of respect for autonomy. While FIGO's position makes no allowances for considerations of respect for autonomy, allowances made by other authors are contradicted by concurrent calls to persuade patients to change their minds if they decide they'd like an elective caesarean delivery. Considerations of beneficence – concerns limited to patients' social-role interests as patients – are given priority over concerns for respect for autonomy in the literature on elective cesarean delivery to date, a topic I will discuss further in chapter four.

1.4 Theory in Medical Ethics II – Respect for Autonomy and Beneficence

This section discusses two groups of theorists, each of whom advocate different conceptions of how considerations of beneficence and respect for autonomy ought to affect our moral evaluations. It should be noted that very few ethicists, if any, openly advocate the primacy of considerations of beneficence over those of respect for autonomy. Such a practice, termed 'paternalism', entails at best, trumping a patient's autonomous choice if it is not deemed to be consistent with their externally identified social-role interests. At worst it entails providing medical treatment to patients without informing them about their condition or obtaining their consent prior to an intervention. The official positions of ethicists, who, as I will argue

below, emphasize beneficence, ought not to, at this point, be described as paternalism. It is more accurate to describe nearly all commentators - advocates of beneficence or respect for autonomy - as debating issues of balance where both principles are given some weight, but where both groups of theorists are more likely to make one principle the deciding factor in the evaluation of any particular case. The real differences between these positions are demonstrated in their handling of difficult or fringe cases. Supporters of autonomy and beneficence agree that physicians should be generally concerned for the well-being of their patients, that patient's individual values should be acknowledged, and that there are goods that are important to people beyond medical values. But where autonomy-oriented theorists could support a medical intervention that produces no medical benefit and perhaps exposes a patient to harm, those who favour beneficence could not. Conversely, while the beneficence-oriented theorists could advocate a violation of respect for autonomy for potentially great medical benefit or to avoid significant harm, those in favour of an emphasis on respect for autonomy would be less willing.

1.4.1 Primacy of Beneficence

Edmund Pellegrino and David Thomasma advocate giving considerations of beneficence the most weight in moral evaluations in medicine. Commentators who promulgate this general view tend to

maintain what might be described as a more traditional view of medicine. This view tends to reject the practice of medical advertising, speaks in terms of the overarching goals of medicine (a version of which is outlined in chapter 3), rejects suggestions that norms in medical ethics are a matter of social convention or consensus, and promotes the notion of the physician as a benevolent and selfless professional.

Pellegrino argues that the ethics of medicine is located within the nature of relationships entailed in medical practice. He describes the condition of being sick as one in which individuals are ontologically and existentially vulnerable and argues that physicians entrusted to help someone in such a state have an obligation to do so in a way that the purpose of the medical intervention – "healing, helping, caring, curing"[46] – can be achieved. The telos of this relationship is to achieve what is technically and morally good for the patient, which is pursued through a "right and good healing and helping act"[47]. Although Pellegrino acknowledges the complex nature of a patient's good and includes the patient as someone who can contribute to determining his or her own needs, he speaks of this notion of "good" almost exclusively in terms of "healing". While "the primacy of the good of the

[46] Edmund D. Pellegrino, "From Medical Ethics to a Moral Philosophy of the Professions" in *The Story of Bioethics*, eds. Jennifer K. Walker, Eran P. Klein (Washington D.C.: Georgetown University Press, 2003), p. 7.
[47] *Ibid.*

patient [is] the *locus ethicus* of the relationship"[48], this notion of good seems only to encompass medical goods. Obligations of beneficence, then, are the priority.

In their book, *For the Patient's Good* [49], Pellegrino and Thomasma elaborate on this position by distinguishing this beneficence-centered approach from paternalistic approaches and those that prioritize respect for autonomy (to be discussed below)[50]. Within this account, Pellegrino and Thomasma advocate for the autonomy and expression of values by both patient and physician, however, this expression is limited by considerations of beneficence. They write: "both autonomy and paternalism are superseded by the obligation to act beneficently; that is to say, the choice of whether one acts to foster autonomy or instead acts paternalistically should be based on what most benefits the patient."[51] They reject the prioritization of respect for autonomy because, they argue, it isn't always the best way to promote the patient's best interests.[52] Their position, stemming from what they perceive to be the nature of the physician-patient relationship, ultimately comes down to an ontological commitment to the primacy of goods over rights.

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[48] *Ibid.*
[49] See: Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good* (New York: Oxford University Press, 1988).
[50] *Ibid.*, pp. 3.
[51] *Ibid.*, pp. 32.
[52] *Ibid.*, pp. 19.

Howard Brody and Franklin G. Miller also maintain a traditional view of medicine and similarly advocate for a conception of medical morality that gives priority to considerations of beneficence. This moral element of medicine, which they call the *internal morality (of medicine)*, encompasses a set of values that gives rise to at least some of the moral duties that all physicians have an obligation to fulfill, and indicates virtues that they must strive to cultivate in order to foster professional integrity as physicians.[53] On Brody and Miller's account these virtues and duties can be captured and fulfilled within a framework of goals and means. They identify the goals of medicine as "(i) the prevention of disease and injury and promotion and maintenance of health", "(ii) relief of pain and suffering caused by maladies", "(iii) the care and cure of those with a malady and the care of those who cannot be cured", and "(iv) the avoidance of premature death and the pursuit of a peaceful death."[54] A list of standards helps delineate the appropriate means by which these goals can be reached. Included on this list are the physician's obligations to maintain technical competence, to avoid misrepresenting their skills and knowledge, and to faithfully uphold patients' interests. One of these standards refers specifically to the physician's duty to "avoid harming the patient in any way that is out of proportion to expected benefit". The

[53] Brody, H, Miller, FG, "The Internal Morality of Medicine: Explication and Application to Managed Care", *Journal of Medicine and Philosophy* 1998, 23, 4:386.
[54] Miller, FG, Brody, H, Chung, KC, "Cosmetic Surgery and the Internal Morality of Medicine", *Cambridge Quarterly of Healthcare Ethics* 2000, 9: 353.

source of this standard derives from "medicine's ... goal as a helping, beneficent practice."[55] Although some notion of patients' interests is mentioned among these standards, this concept is also said to stem from the goal of medicine as a "helping, beneficent practice" and so seems intended to refer to a patient's social-role interests only. Under this conception medicine cannot, and perhaps ought not to, help patients achieve their subjective or deliberative interests – interests related to patient autonomy.

1.4.2 Primacy of Respect for Autonomy

Robert Veatch and Tristam Engelhardt take an opposing view, arguing in favour of prioritizing considerations of respect for autonomy. Veatch argues that the primacy of patient autonomy is clearly demonstrated in the way medicine seems to work. He observes that, as demonstrated in the informed consent debate in the US, patient autonomy is always taken to have priority over the physician's desire to treat the patient.[56] If this description is evidence for a considered moral judgment, then, he argues, any conflict between moral principles cannot be resolved by balancing "patient well-being" and respect for autonomy. Rather, respect for patient autonomy must be given priority.[57]

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[55] Brody, 1998, pp. 388.
[56] Robert M. Veatch, "Revisiting *A Theory of Medical Ethics*: Main themes and Anticipated Changes" in *The Story of Bioethics,* eds. Jennifer K. Walker, Eran P. Klein (Washington DC: Georgetown University Press, 2003), pp. 76.
[57] *Ibid.*, pp.77.

Veatch supports this view by appealing to a version of contract theory to show that issues in medical ethics are informed by more than just considerations of a patient's medical well-being. He identifies a category of principles as "duty-based" which includes duties of justice and respect for autonomy. These norms, he claims share a "right-making" feature which is independent of consequences. These principles are distinct from those of beneficence and non-maleficence which, he argues, are consequentialist principles.[58] Veatch assigns lexical priority to duty-based principles over consequentialist ones. It is this group of duty-based principles that restrict a physician's ability to violate patient autonomy in order to benefit the patient. In other words, only when these duty-based principles have been met, he argues, can a physician fulfill her obligations of beneficence.[59] Veatch does not justify his prioritization of respect for autonomy over beneficence because doing so does a better job at achieving some larger notion of patient good, nor does he claim that doing so is always in the patient's best interests. Rather, and this is perhaps a large difference between those who argue for primacy of beneficence and those who advocate for the primacy of respect for autonomy, respect for autonomy is favoured because it is seen as "an independent right-making characteristic of action."[60]

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[58] *Ibid.*, pp. 75.
[59] *Ibid.*, pp. 77.
[60] *Ibid.*, pp. 81.

Tristam Engelhardt, using very different metaphysical assumptions, similarly gives priority to the principle of respect for autonomy.[61] He rejects moral realism and instead argues that moral frameworks and the norms therein arise from agreements made within a society or cultural group. As such, there is no universal morality and the moral ontology is defined internally; definitions of 'healing' and 'medicine' can vary from group to group. A secular humanist, Engelhardt sees respect for individual autonomy as necessary for the maintenance of a moral framework and the dispensation of punishment. He explains:

> "The principle of respect for autonomy as a summary of the core of the morality of mutual respect must be embraced insofar as one coherently thinks of oneself as making claims to respect, or regarding persons in terms of their worthiness of blame or praise... If one does not participate in this world of mutual respect, then one is left with using force without even a purported justification... The morality of mutual respect, through the principle of autonomy, gives boundaries to morality generally."[62]

Engelhardt concludes that respect for autonomy necessarily unites individuals in moral life and therefore is a necessary condition for any subsequent moral dialogue. It cannot make sense, then, to discuss

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[61] H. Tristam Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University press, 1986), pp 80, 82.
[62] H. Tristam Engelhardt Jr., 1986, pp. 80.

obligations of beneficence before, let alone weigh them more heavily than those of respect for autonomy.

Whether one approaches moral dilemmas in medicine with assumptions of the primacy of beneficence or the primacy of respect for autonomy depends on one's underlying and fundamental philosophical commitments. This discussion suggests that there are equally good arguments for the primacy of beneficence over respect for autonomy and vice versa. I will return to discuss the implications of this in Chapter 4.

In order to fully understand the content and rationale of behind the conflict related to elective caesarean delivery, one must be aware of the medical risks presented by elective caesarean delivery. In the following section I discuss those that are presented to the pregnant woman. Those presented to the foetus will be discussed in the following chapter.

1.5 Maternal Risks Presented by Elective Caesarean Delivery

Uncomplicated vaginal deliveries present risks of anal sphincter disruption and pelvic floor disorders such as urinary and faecal incontinence, and prolapse.[63,64,65] While these risks are avoided by choosing to have a

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[63] Devendra K, Arulkumaran, S, Should Doctors Perform an Elective Caesarean Section on Request? *Annals Academy of Medicine* 2003, Vol. 32, No. 5, 577-582.
[64] Paterson-Brown, S, Should doctors perform an elective caesarean section on request? Yes, as long as the woman is fully informed, *British Medical Journal 1998*, 317:462-463.
[65] Minkoff, H, Chervenak FA, Elective Primary Cesarean Delivery, *New England Journal of Medicine* 2003; 348: 10, 946-950.

caesarean delivery, caesareans also present risks. Opting for caesarean over vaginal delivery is best described as a trading of risk, rather than an escape from it altogether.

Including an extended discussion of maternal risks in this project might be thought to conflict with my thesis and so requires some explanation. As will become clear, I advocate for a shift *away* from assumptions of beneficence (based on medical risk/benefit analysis) in the ethical analysis of elective caesarean delivery so one would expect that it would be most consistent with my arguments to give less emphasis to empirical details, not more. This section is important however because it describes the severity and range of risks presented to the pregnant woman by elective caesarean sections.

Some might object to a moral account that prioritizes respect for autonomy because it implies that a patient ought to be taken at their word no matter what the request. An outrageous request, say, one that places the patient squarely in harms way where there seems little need for it, or where no benefit of *any* kind can be identified, could reasonably be taken as an indication of decreased competency of that patient. Surely, the objection might go, we want an account that allows us to make such a judgment. If I were arguing for an absolute primacy of respect for autonomy in every moral dilemma I would be required to address this objection directly. As this is *not*

my intention, I need only to show that choosing the risks of elective caesarean delivery over those presented by vaginal delivery is something that a competent person could reasonably do. The probability of these risks, in my opinion, is sufficiently low for an individual to reasonably choose to expose themselves to them to achieve some other sorts of benefits.

Three broad categories of risks are presented by elective caesarean delivery: mortality, morbidity, and risks in future pregnancy. Compared to mortality rates in vaginal birth, the most recent studies find that caesarean section births present a 2 to 3.8 fold increase in maternal mortality, citing pulmonary embolism as the primary cause of death.[66,67, 68] The degree to which these statistics inform *elective* caesareans is unclear. It has been noted by a few authors that studies that generate these statistics often fail to differentiate between planned cesareans by request and those conducted after a failed attempt at vaginal delivery, often done under emergency conditions and using general, rather than local anaesthesia as would be the normal

[66] Lilford RJ, van Coeverden de Groot HA, Moore PJ, Bingham P, The relative risks of cesarean section (intrapartum and elective) and vaginal delivery: a detailed analysis to exclude the effects of medical disorders and other acute pre-existing physiological disturbances, *Br J Obstet Gynaecol* 1990; 97: 883-892, cited in Penna L, Arulkumaran S, Cesarean section for non-medical reasons. *International Journal of Gynecology and Obstetrics*, 82, 399-409.

[67] Department of Health, Welsh Office, Scottish Office Home and Health Department, Department of Health and Social Services, Northern Ireland, Report on confidential enquiries into maternal deaths in the United Kingdom 1991-3, London: HMSO, 1997; Department of Health, Welsh Office, Scottish Office Home and Health Department, Department of Health and Social Services, Northern Ireland, Report on confidential enquiries into maternal deaths in the United Kingdom 1988-90, London: HMSO, 1997; Hall M F, Bewley S, Maternal mortality and mode of delivery, *Lancet* 1999; 354:776; all three cited in, Devendra et al. 2003, pp. 577-582.

[68] National Institute of Clinical Excellence, Scottish Executive Health Department, Department of Health, Social Services, and Public Safety, "Why mothers die 1997-1999: the confidential enquiries into maternal deaths in the UK", London: RCOG Press, 2003; cited in Minkoff et al. 2003, pp. 946-950.

procedure in elective caesarean delivery.[69, 70] In studies where mortality rates of elective caesareans have been analyzed independently of non-elective procedures, results show that these mortality rates are *lower* than those presented by vaginal birth.[71]

In terms of morbidity (occurrence of disease) maternal risks presented by elective caesarean delivery include infection, haemorrhage, ileus, pulmonary embolism and Mendelson's syndrome.[72, 73, 74] According to one study, infective morbidity relative to vaginal delivery is said to be increased 5 to 20-fold.[75] The instance of hysterectomy due to haemorrhage after caesarean is reported to be 10 times that after vaginal delivery.[76, 77] Again, many of these studies do not differentiate requested pre-labour caesareans from non-requested procedures. There is some evidence that these rates would be lower if studies looked at instances of morbidity in caesareans on demand only.[78]

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[69] Paterson-Brown,1998, pp. 462-463.
[70] Minkoff et al., 2003, pp. 947.
[71] Lucas DN, Yentis SM, Kinsella SM et al, Urgency of cesarean section: a new classification. *J R Soc Med* 2000; 93: 346 – 50; Yoles I, Maschiach S, Increased maternal mortality in cesarean section as compared to vaginal delivery? Time for re-evaluation, *Am J Obstet Gynecol* 1998; 178: Suppl.: S78. abstract; both cited in Minkoff et al., 2003, pp. 948.
[72] Amu O, Rajendran S, Bolaji II, Should doctors perform an elective caesarean section on request? Maternal choice alone should not determine method of delivery, *British Medical Journal* 2003, 317: 463-465.
[73] Devendra et al., 2003, pp. 578.
[74] Minkoff et al., 2003, pp. 948.
[75] Henderson E, Love EJ, Incidence of hospital-acquired infections associated with cesarean section, *J Hosp Infect* 1995, 29:245-255; cited in Penna et al., 2003, pp. 404.
[76] Amu et al., 2003, pp. 464.
[77] Devendra et al., 2003, pp. 578.
[78] Molloy D, Caesarean section: The end point in reproductive emancipation for women? *Obstetrics and Gynecology* 2004, vol. 6, no. 3, pp. 187-188,

Perhaps the most serious risks presented by elective caesarean delivery are of conditions that affect subsequent pregnancies. There is evidence to suggest that women who deliver via caesarean are at increased risk of adhesion formation, uterine rupture, placenta previa, placenta accrete, placental abruption, intestinal obstruction, bladder injury, and ectopic pregnancies all of which have serious implications for future pregnancies and delivery.[79, 80, 81, 82] A recent study suggests that caesarean delivery is associated with decreased fecundity as indicated by increased time required to conceive.[83]

Although they occur at low rates, elective caesarean delivery presents some serious risks that individuals must consider carefully before choosing this mode of delivery. There is an unfortunate lack of studies of *elective* procedures, however. There are theoretical reasons to believe that data that include emergency or un-planned caesareans tend to indicate higher rates of mortality and morbidity than would likely be indicated by study of elective cesareans alone.

Given that, in the context of cosmetic surgery (to be discussed in Chapter 3) individuals can volunteer for major and invasive surgery (e.g.

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[79] Penna et al., 2003, pp. 404-405.
[80] Amu et al., 2003, pp. 464.
[81] Devendra et al., 2003, pp. 578.
[82] Minkoff et al., 2003, pp. 948.
[83] Murphy D, Stirrat G, Heron J, The relationship between cesarean section and subfertility in a population-based sample of 14541 pregnancies, *Hum Reprod* 2002, 17: 1914-1917; cited in Penna et al., 2003, pp. 405.

breast/pectoral implants, liposuction) without having their sanity brought into question, an individual can reasonably incur risks presented by elective caesarean delivery.

1.6 Conclusion

So far, the issues presented by elective caesarean delivery have only been evaluated with the assumption of the moral primacy of beneficence. Under McCullough and Chervenak's account, this entails the primary concern for the patient's social-role interests – that is, interests that can be identified and met by medicine. Such prioritization has coloured all ethical critiques of elective caesarean delivery to various degrees and has precluded an account that emphasizes considerations of respect for autonomy (consisting in the patient's subjective and deliberative interests). The discussion in this chapter reveals that most commentators on elective caesarean delivery share an approach to moral dilemmas that prioritizes patients' social-role interests. This approach is well supported in the literature by Pellegrino, Thomasma, Brody, and Miller. However, an initial discussion of fundamental theory in medical ethics shows that there are equally good reasons for giving priority to beneficence or respect for autonomy, suggesting that it is time to at least consider an evaluation of

elective caesarean delivery from the perspective of primacy of respect for autonomy.

Chapter 2

Risks of Elective Caesarean Delivery and the Moral Status of the Foetus

2.1 Introduction

If it is the case that elective caesarean sections do not present increased risk to the foetus relative to vaginal birth, it seems reasonable to conclude that we can remove considerations of the foetus from the discussion. Historically, considerations of the moral status of the foetus have contributed to great controversy in matters relating to pregnancy and caesarean section in particular, however.

Moral and legal conflict between maternal autonomy and considerations of the foetus has manifested itself in various ways in the last twenty years. Child abuse charges have been pressed against drug-addicted mothers for having given birth to children who are addicted or otherwise

harmed by their addictions.[84] Other cases have seen charges pressed against pregnant woman who have refused to seek medical care or prenatal treatment resulting in fetal death or future harm to the child. The first of two well-known Canadian cases describes a pregnant woman addicted to glue sniffing who was inappropriately judged as incompetent so that under the mental health act, she could be incarcerated to prevent her from using for the duration of her pregnancy.[85] The second case concerns a suit brought against a mother by her son for injuries he sustained *in utero* in an automobile accident that he alleged were caused by her negligent driving.[86] The judgment of this case has important implications for the legal liability of the mother for all matter of pre-natal injuries.[87]

In this same time period there was an on-going controversy regarding the morally appropriate course of action when faced with a pregnant woman who refuses a medically indicated caesarean section. During the 1980s and 1990s several court cases came about in the US and the UK where emergency court orders were sought to force women to endure caesarean deliveries against their wishes[88]. In many cases, it was successfully argued that the

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[84] See, *Whither* v. *State of South Carolina* 492 SE 2d 777 (SC 1997).
[85] *Winnepeg Child and Family Services (Northwest Area)* v. *DFG* (1996) 10 WWR 111.
[86] *Dobson* v. *Dobson* [1999] 2 Can SCR 753.
[87] See discussion in, Rosamund Scott, *Rights, Duties and the Body, Legal and Ethics of the Maternal-Fetal Conflict* (Portland OR,: Hart Publishing, 2002) pp. 320-321.
[88] Curran, WJ. Court-ordered cesarean sections receive judicial defeat, *The New England Journal of Medicine*1990, 323(7): 489-492 (Aug. 16th); see *Jefferson* v. *Griffin Spalding County Hospital Authority* Ga274 SE 2d 457 (1981); *Taft* v. *Taft* 388 Mass 331, 446 NE 2d 395 (1983) among

foetus qualified as a child in need of protection. This was the initial judgment in another Canadian case, *Re Baby R* (1988)[89]. After the mother refused a recommended caesarean section in this instance, the 'child' was "apprehended" by the Superintended of *Family and Child Services* under the British Columbia Family and Child Services Act giving him the power to authorize the caesarean section.

By the mid nineties, these kinds of judgments were becoming less common and the rights of the pregnant woman were reasserted. The case of *Baby Boy Doe* (1994)[90] endorsed that women can refuse a recommended caesarean section for any reason. A settled conclusion on the matter was, and remains out of reach, however. This is particularly true for the United States which has always had varying policies regarding maternal-foetal conflict from state to state, not to mention states which never really reached a firm decision on the matter. Although its presence in the literature has faded somewhat in the last five to ten years, the matter of forced caesareans and concerns regarding the moral status of the foetus have always been subject to renewed discussion. This is reflected by the recent re-emergence of debates

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many others. For a lengthy list of cases relating to maternal foetal conflict, see Scott, 2002, pp. xiii – xix.

[89] 53 DLR 4th (69); the case was later overturned by the B.C. Supreme Court on grounds that the foetus was not a child within the meaning of the act. See discussion in Scott, 2002, pp. 345 n.249.

[90] 632 NE 2d 326 (Ill App 1 Dist 1994).

surrounding the moral status of the foetus both in the literature[91] and in the courts. Scott Peterson, who after allegedly killing his pregnant wife, was found guilty of not one, but two counts of murder. This case bolstered support for the Unborn Victims of Violence Act (first introduced in 1997) which was signed into law by US President George W. Bush in April, 2004.[92] Prior to this event, in January 2004 an Illinois woman was charged with murder after refusing to undergo a caesarean section, when her child died as a result.[93] Issues of maternal-foetal conflict and underlying and ongoing concerns for foetal well-being are ever present in the moral dilemmas in child birth and reproduction and so merit serious consideration in relation to the issue of elective caesarean delivery.

There is a second, less significant but more specific reason why a discussion of the status of the foetus is warranted in this project. In the literature, certain authors have mentioned the possibility of conceiving of elective caesareans as we do cosmetic surgery where the patient's own decision determines whether or not they have the procedure. This approach has thus far, been rejected on the basis that unlike most cosmetic surgery procedures, considerations of the foetus are relevant to ethical evaluations of elective caesarean delivery. In the context of caesareans on demand, it is

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[91] See. Lyng K, Syse A, Bordahl E, Can cesarean section be performed without the women's consent? *Acta Obstet Gynecol Scand* 2005, 84: 39-42.
[92] United States Public Law 108-212-Apr. 1, 2004. Unborn Victims of Violence Act of 2004.
[93] *The State of Utah* v. *Mary Ann Rowland.* Salt Lake City, UT: District Attorney's Office. DAO #04004311 Case no. 041004311, 2004.

claimed that a woman is not only deciding for herself, but also for the "foetal patient".[94] In this chapter I argue the performance of an elective caesarean section is morally permissible under any moral conception of the foetus[95]. Discussion of this topic is particularly called for in evaluations of elective caesarean delivery because the foetus is, at 39 weeks, viable, and nearly fully developed. The intuitions about our moral duties towards these entities is often that late-gestational-age foetuses merit some, if not a great degree of moral consideration.

I begin by outlining several positions on the moral status of the foetus, including after each, a discussion of the implications of each conception for our evaluations of elective caesarean delivery. This analysis primarily considers the foetus at the developmental stage and physiological state presented in the context of this procedure. At 39 weeks gestational age, the foetus is viable, has brain activity and some degree of sentience. It is still located inside the uterus and therefore is engaged in an intimate physiological relationship with the woman, dependent on her to maintain a healthy life-sustaining environment. I do not intend to argue in favor of one particular moral conception of the foetus, but is instead hope to show that elective caesarean delivery can be morally consistent with many moral

[94] Minkoff, H, Powderly, KR, Chervenak, F, McCullough, LB, "Ethical Dimensions of Elective Primary Cesarean Delivery", *Obstetrics and Gynecology* 2004, 103 (2): 387 – 392.

[95] I use "foetus" generally to refer to unborn humans at any stage of development. In this case, as indicated in the text this term will refer largely, but not be restricted to, actual foetuses, defined as the developing entity from 3 months gestational age to birth.

conception of the foetus. This then allows me to set aside any further considerations of the foetus for the remainder of the project. Before I begin this discussion, I will provide a brief overview of the medical risks and benefits for the foetus presented by this procedure as these have important implications for many of the positions.

2.2 Risks and Benefits presented to the Foetus by Elective Caesarean Delivery

Empirical evidence indicates that there *are* risks posed to the foetus by elective caesarean delivery but it isn't clear that these risks are greater, or more serious than those posed by vaginal delivery. Elective cesarean birth may avoid the risks posed by vaginal birth such as late-term stillbirth, cerebral palsy related to intra-partum hypoxia, cranial and skeletal injuries[96], and nerve injuries.[97] Conversely, infants delivered by caesarean more frequently display respiratory distress syndrome and transient tachypnoea[98]. Although there is controversy, many commentators agree that if performed with the appropriate precautions, risks faced by neonates delivered by

[96] Penna, L, Arulkumaran, S, "Cesarean section for non-medical reasons", *International Journal of Gynecology and Obstetrics* 2003 , 82, 399-409, pp. 401.
[97] Minkoff, H, Chervenak, FA, 2003, pp. 947.
[98] Devendra, K, Arulkumaran, S, 2003, pp.579.

elective caesarean section are minimal.[99] For my purposes, it doesn't need to be clear that elective caesarean delivery is, overall, *safer* for neonates, only that it doesn't pose risks in addition to those presented by vaginal delivery. It is plausible, based on the evidence, to conclude that from the perspective of the foetus, the procedure does not entail exposure to increased risk.

The literature presents a wide spectrum of views on the moral status of the foetus. At one end, foetuses are described as having no moral claim at all while at the other, they are said to carry the full compliment of rights, equal to those held by a normal adult. I will outlined the following five conceptions: foetus as indistinct from pregnant woman; foetus as having no rights; foetus as contributing to human value, foetus as possessing human dignity; foetus as patient but not person; and foetus as person.

Two underlying concepts are present in the majority of these conceptions: the notion of conferred rights and the argument for potentiality. The latter - the argument for potential persons - is especially pertinent for moderate accounts of the status of the foetus. Some commentators argue that the foetus merits certain kinds of treatment in response to what they will likely become rather than what they are in the present. Similarly presented in these moderate positions is the view that rights can, and ought to be conferred to certain entities not in response to their inherent nature, but

[99] Minkoff, H, Chervenak, FA, 2003, pp. 949.

because these entities are externally identified as valuable or deserving of protection by others.

2.3 Moral Conception of the Foetus

2.3.1 Foetus and Woman as a single unit

Barbara Katz Rothman argues for a women-centered model of pregnancy which describes the woman and the foetus as a single unit, rendering talk about any significant kind of separation between the two, let alone the possibility of separate rights for each, unintelligible. She writes in reference to discourse on maternal-foetal conflict, "It is not the rights of one autonomous being set against the rights of another, but the profound alienation of the woman set against part of herself."[100] For Rothman, the foetus and the woman are one and the same[101]. Although it will one-day be somebody else, it is not for the time being.

This view is problematic for many because it fails to account for the underlying intuition that there *is* in fact something separate or significantly distinct about a foetus *in utero* and that certain actions, either by the woman

[100] Barbara Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* (New York: Norton, 1989) pp 161.

[101] This view resembles those views that deny any rights to the foetus. In either case, only one set of rights is acknowledged and considered - that of the mother. These two are importantly distinct however. Where the foetus is identified as a distinct entity but is judged to lack qualities that make it deserving of moral consideration (or at least moral consideration that would in any way restrict the woman's activities/choices) it is conceivable that some kind of discovery could be made that would demonstrate that the foetus possessed such characteristics. It would then be said to merit the accompanying rights and moral claims as well. Under Rothman's conception, there would never be measure of foetal qualities, because to do so would be to assume that there is something distinct about the foetus that would make such measurements morally relevant. Rothman makes no such assumption.

or some other, have an effect on the foetus and so are morally significant. Be the reasons related to the physical – a separate heart beat, a different genetic code, independent and spontaneous movement – or the causal – that high alcohol consumption affects brain development, drug abuse in pregnancy can produce infant addicts etc. - for many, even if it turns out that a foetus has no moral claim whatsoever, it makes sense to think of it as distinct. Laura Purdy articulates support for this view exclaiming that women's choices in pregnancy can *and do* affect the life of their foetuses.[102] These effects are ultimately exhibited in another being (the person the foetus becomes), not uniquely in herself.

Given that Rothman and other proponents of this view do not make any kind of distinction between the pregnant woman and the gestating foetus, it is incoherent then for them to make reference to a "foetal patient" and to hold any further deliberations on its role in a particular procedure or event. Necessarily, considerations of the foetus do not factor into moral deliberations of elective caesarean delivery[103].

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[102] Laura M. Purdy, *Reproducing Persons, Issues in Feminist Bioethics* (Ithaca: Cornell University Press. 1996) pp. 92.

[103] Although there may be other reasons to reject it. Rothman herself would likely argue against making ECS available.

2.3.2 No Foetal Rights

In her discussion on abortion, Mary Anne Warren argues that a foetus is not, morally speaking, a person[104] and as a result, is not part of our moral community and therefore does not merit full moral rights.[105] Warren outlines five criteria for personhood, a subset of which need minimally to be fulfilled in order for a being to be identified as a person and therefore as a member of the moral community. They are:

(1) consciousness (of objects and events external and/or internal to the being), and in particular the capacity to feel pain.

(2) reasoning (the *developed* capacity to solve new and relatively complex problems).

(3) self-motivated activity (activity which is relatively independent of either genetic or direct external control).

(4) The capacity to communicate by whatever means, messages of an indefinite variety of types, that is, not just with an indefinite number of possible contents, but on indefinitely many possible topics.

(5) The presence of self-concepts, and self awareness, either individual or racial, or both.[106]

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[104] She highlights an important distinction between genetic and moral humanity. To be human in the genetic sense entails being a member of a genetic community – namely the human species. In this sense, foetuses are human. A human in the moral sense is a "full fledged member of the moral community." She refers to this sort of humanity as 'personhood'.

[105] Warren, MA, "On the Moral and Legal Status of Abortion", *The Monist* 1973, 57 (Jan 73), pp. 43-61.

[106] *Ibid.*, pp. 55.

It is not necessary for an individual to fulfill all five criteria to be a person. Warren suggests that fulfilling (1) and (2) or perhaps (1) – (3) could be sufficient for personhood. However, a being who fails to satisfy even one criterion fails to attain personhood.

Tristam Engelhardt takes a similar approach to demarcating the moral community, defining persons "in the strict sense" as those who can be "concerned about moral arguments and... are convinced by them. They must be self-conscious, rational, free to choose, and must possess moral concern."[107] A late term foetus seems to fulfill Warren's first criterion for personhood but none of the others, and so is not a person under her conception. The foetus fails to fulfill Engelhardt's criteria also. Although both Warren and Engelhardt recognize the foetus as a distinct living entity, the character of the foetus is such that it cannot have claims against others and Warren, at least, concludes that we have no duty towards them as a result.[108] We could imagine a position where the foetus *has* certain rights but that these rights are consistently trumped by the rights of the pregnant woman. If this is the case for either Warren or Engelhardt, then any right the

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[107] H.T. Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986) pp.105.

[108] Englehardt argues that fetuses are the producers' property and they (the parents) therefore are permitted to dispose of the foetuses as they see fit. In the case of a surviving fetus however, Engelhardt argues that parents (particularly mothers) have a duty not to harm or "injure the future person the fetus will become." (1986, pp. 220).

foetus may be said to have is very weak indeed, given its almost total lack of acknowledgement.[109]

While Warren implies an outright rejection of conferred rights to pre-persons at any stage including those of infants and foetuses, Engelhardt argues that during this time it might be appropriate for others to confer rights to an infant and perhaps even at the foetal stage allowing it to become a person, but only "in the social sense"[110]. The "social sense" of personhood is justified in terms of various utilitarian and other consequentialist considerations, such as the desire to promote behaviours that serve to protect persons in the strict sense. Personhood in the "social sense" and its accompanying rights are conferred to the foetus by members of a particular community surrounding it, often composed of parents, grandparents, other relatives and friends. These rights and their resulting claims, on his account, are not absolute and may conflict with the rights of persons in the strict sense. Engelhardt writes, "the obligations imposed by others in terms of the social role of persons will thus be prima facie obligations, which in particular circumstances can be set aside."[111]

The argument for potentiality contends that foetuses merit certain moral considerations in virtue of their potential for being actual persons in

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[109] Warren, in her article "Moral and Legal Status of Abortion", muses that a foetus might be said to have as much of a right to life as a newborn guppy, at pp. 58, implying perhaps that foetuses have *some* rights.
[110] *Ibid.*, pp. 116.
[111] *Ibid.*, pp. 118.

the future. Warren argues that a potential person cannot have a right to life in virtue of that potential. In the case that a potential person has other rights, those of an actual person will always trump them.[112] Engelhardt, taking a more complex position, acknowledges that we cannot have duties to non-existent individuals, but also argues that one still has a duty "not to malevolently injure the fetus"[113] out of consideration for the persons they will become. Under this account, a pregnant woman is permitted to make choices that may entail harms for the foetus provided "(1) the women's harmful omissions and commissions are not malevolent, and (2) the anticipated state of the future possible person is not so disadvantageous as to make life not worth living."[114]

Under the definitions of personhood outlined by Warren and Engelhardt, the full-term foetus does not qualify as a person and therefore is not a member of the moral community and so has minimal moral claim. Warren's position is consistent with the conclusion that considerations of the foetus ought not to restrict the pregnant woman's autonomous choice in considering elective caesarean delivery.

Engelhardt's position might differ from Warren's for two reasons. First, if the family has conferred rights to that foetus and it is therefore a

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[112] Warren, MA, 1973, pp. 59.
[113] Engelhardt, T, 1986, pp. 217, 220.
[114] *Ibid.*, pp. 226.

person in the "social sense" there may be reason for that family to take pause to consider more fully the impacts of the procedure on the foetus. Second reflecting Purdy's comments that a pregnant woman's actions affect the foetus, Engelhardt might be concerned regarding the extent to which the procedure may present harms for the future person the foetus will likely become. It would be morally permissible to choose to have a caesarean section provided the intent is not specifically *to harm* the foetus, and that the harm to the future person would not be so great as to make life not worth living. Although potentially harmful to both the foetus and the mother[115], current evidence indicates that the level of risk presented by elective caesarean sections to the foetus is similar to risk presented by vaginal delivery and so would be a poor choice if one intended to expose the foetus to greater harms. Further, the outcomes of the most probable harms (respiratory distress) are fairly mild, and certainly not so severe as to make life not worth living. It would seem then, that under these similar conceptions of the moral status of the foetus, elective caesarean sections would be permitted under Engelhardt's conception also.

2.3.3 Foetus as contributing to Human Value, Foetal Dignity

Both Warren and Engelhardt make reference to the foetus as contributing to some greater good or good for others. Engelhardt in

[115] Discussed later in this chapter.

particular describes how parents and family might confer value on the developing foetus[116]. Whether or not the foetus contributes to human value, on his conception, depends on decisions made by the relevant individuals (usually family), and not on the inherent nature of the foetus itself; this type of value lacks universal moral authority. We can imagine another position where the foetus is identified as holding a certain kind inherent of value *that has* moral pull, in other words, value that we have an obligation to respond to in such a way that sustains and/or maximizes this value. This view takes a more utilitarian approach and bypasses the issues of personhood.

Engelhardt, in the context of conferring rights to *infants*, discusses reasons for acknowledging them as persons in the social sense. Doing so, he says, promotes virtues of sympathy and care for human life, particularly life perceived to be defenseless and fragile. It also encourages good practices in child rearing which, when universalized, ensures a greater degree of flourishing among persons in the strict sense.[117] We might identify these as valuable consequences of a healthy pregnancy also. In some sense, the presence of the foetus (i.e. a pregnancy[118]) creates conditions where the aforementioned virtues of care for fragile human life and sympathy are

[116] He also discusses how the opposite may obtain. If the foetus comes into being under negative circumstances or is somehow contributing harms to the woman or the family, it may also be seen as threatening, and be disrespected, and disliked as result.
[117] Engelhardt, 1986, pp. 117.
[118] It might be a bit of a stretch to speak of these values as being 'contributed' by the foetus. It is the pregnancy itself, and most importantly the woman whose actions ultimately determine whether this value is contributed. Still, the presence of the foetus is a necessary condition for pregnancy, so for the time being, we can identify it as contributing in some sense.

fostered. Also, encouraging behaviors that maximize foetal well being creates a culture of child bearing that contributes to the overall fitness of persons in general. In these ways, a foetus can be said to be contributing to human value.

Although we might agree that we have a moral duty to maximize these valuable elements that are co-extensive with pregnancy it does not guarantee necessary and unique consideration of the foetus because these ends could conceivably be achieved in other ways. We should then consider values that are necessarily related to the conditions of foetal gestation. Mary Mahowald proposes such a view when she identifies developing human life as a "positive human value."[119] The very existence of the foetus is seen as valuable and something worth preserving. [120] The extent to which persons would be obligated to respond to this inherent value depends on the strength of its moral pull. Minimally, it would seem to require that in acknowledgment of this value, the foetus merits *some* consideration and that in certain cases, the pregnant woman's desires could be curbed out of respect for this inherent value.

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[119] Mahowald, MB. "Is there Life after Roe vs. Wade?", printed in Howell, JH, Sale, WF (eds) *Life Choices, A Hastings Center Introduction to Bioethics* (Washington DC: Georgetown University Press, 1995) 96-109, pp.102.

[120] Although it is possible that certain values be inherently connected to the gestating foetus, that of developing human life, for example, a utilitarian approach does not guarantee the protection and priority of consideration of the foetus in all cases however. The utilitarian is most concerned with maximizing value or happiness or the good in general, and this can come at the cost of foetal preservation. A mother who acknowledges all the aforementioned values contributed by a gestating foetus may still decide to terminate a pregnancy if it is the only way she can continue to care for her six other children.

Ascribing some kind of human dignity to the foetus avoids the pitfalls of a utilitarian approach and issues of personhood. If a foetus inherently possesses a degree of human dignity is seems to merit *some* kind of consideration in pre-natal decision-making. Gilbert Meilaender, a commentator on abortion, expresses this concern: "The claim, "its my body to do with as I wish" becomes more worrisome if that body is nourishing another human life equal in dignity."[121] The argument for the moral pull of human dignity is often presented alongside evaluations of definitions of personhood which are criticized for arbitrarily restricting the moral community. This argument entails a rejection of the genetic humanity/moral humanity distinction, in favour of including all human beings in the moral sphere. Meilaender justifies this inclusive approach in terms of a shared feeling of kinship among all human beings, even those who are not rational or self-conscious. It is this shared "embodied humanity" that should motivate us to take care and protect the "weakest members of the human community."[122]

It is difficult to know the consequences of this view on moral evaluations of elective caesarean delivery. Proponents reject any necessity of the doctrine of personhood but fail to clarify the practical implications of the

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[121] Meilander, Gilbert. "Abortion: The Right to an Argument", printed in Howell, JH, Sale, WF, (eds) *Life Choices, A Hastings Center Introduction to Bioethics* (Washington DC: Georgetown University Press, 1995) pp. 87 – 95.
[122] Meilaender, G, 1995, pp.92.

'human dignity' view. Quantitatively it is unclear if all humans have equal dignity in virtue of being humans, or if some humans have more than others. Is having equal dignity tantamount to having equal rights? In the context of abortion, where this discussion was originally located, the proponents of this view think it is clear that this human dignity has sufficient moral pull to render it morally impermissible to abort a foetus. Minimally then, being in possession of human dignity amounts to some kind of right to life.

To speak of conferred rights and the argument for potentiality in the context of foetal dignity or foetal contributions to value makes little sense. First of all, the rights/duties terminology has been purposely rejected in either case. Speaking in terms of conferral of dignity or value doesn't make sense either. Instead of external others deciding to treat an entity in a certain way, foetuses possess inherent features that merit certain treatment. To take Mahowald's example of developing human life as value, a foetus, as a living developing human entity, necessarily contributes to this value without requiring that it be conferred on the foetus. Dignity, something inherent to all humans, is again something that is therefore inherent to the human foetus and so it need not be conferred to the foetus in order for it to be in possession of this dignity.

Similarly, discourse of value and dignity need not include discussions of foetal consideration in virtue of one day being a person precisely because

this argument for potentiality reinforces an artificial moral distinction between foetuses and 'people'. The value contributed by a foetus in the present is not affected by possible future value contributed by the person the foetus may become. On this account, the concept of dignity applies by definition, to humans at every stage of life, with whatever capabilities.

These positions are highly significant because they capture some of the subtle and ineluctable intuitive and emotional responses to pregnancy, foetuses, and childbirth that contribute to hesitancies, doubts, and concerns experienced by family, physicians, and the general public when faced with moral dilemmas in these areas. These concerns can be related to larger issues of respect for persons, the integrity of relationships, and sanctity of certain processes.

I doubt there is a single, well-defined, universally accepted account of how elective caesarean delivery fairs under this conception of the foetus due to a combination of two reasons. First, relative to other ethical quandaries involving foetuses where one might use arguments from dignity - abortion, foetal experimentation, and in vitro fertilization – elective caesarean delivery presents relatively little risk to the foetus. It is not a matter of necessary foetal harm or death. Second, accounts of foetal dignity and value (including those outlined in this chapter) are underdetermined and so leave much open to interpretation. They have an elastic nature that allows for a broader range

of accepted application (which is not the case with rights, for example). It isn't unusual for people to speak of the dignity of the dead, or dignity for certain non-human animals. And when faced with an entity that has this dignity, it isn't clear what kind of treatment or behaviours are required. Notions of value seem to accompany similar problems in their practical implications, at least in dealing with moderate issues.

Despite, or perhaps, because of these features of dignity and value, it is reasonable that elective caesarean delivery would be determined to be morally permissible under this moral conception of the foetus because it is compatible with acknowledging foetal dignity. In the early stages this dignity can be respected by approaching the decision of whether or not to deliver via caesarean carefully ensuring that the foetus be acknowledged as a participating entity. Beyond this, such dignity minimally requires that the impacts of the procedure on the foetus be acknowledged and that the foetus be shielded from unnecessary risks of harm. As indicated above, there is no evidence to indicate that the foetus is exposed to increase risk during an elective caesarean delivery so it is compatible with its dignity to carry out the procedure. In terms of contributing to value, this form of delivery maintains conditions for the foetus to contribute value (either through the development of human life, the value of a healthy gestational period etc.) and is compatible with acknowledging the value contributed by the fetus.

2.3.4 Foetus as patient, but not necessarily a person

Laurence McCullough and Frank Chervenak argue that the fetus can be identified as a patient without needing to settle whether or not it is, morally speaking, a person.[123] Their argument rests on three premises. First, that the foetus has a number of interests. It has an interest in obtaining independent moral status as well as social-role interests which, as already outlined in Chapter 1 include: the prevention of premature or unnecessary death *and* the prevention, cure, or at least management of disease, injury, handicap, and unnecessary pain and suffering[124]. They argue that foetuses have these social-role interests in virtue of the need to have them met in order to attain an independent moral status (an obvious human good). Their second premise is that duties of beneficence are based in medical competencies. That is, given that these social-role interests can be externally identified, if appropriate medical treatments exist and can reliably be expected to uphold these interests, then physicians, other medical professionals, and family have an obligation to provide these treatments (or the conditions to obtain these treatments) in virtue of the effectiveness of the intervention regardless of whether the patient is a person or not. The third premise is that the pregnant woman is a moral fiduciary for her foetus, and

[123] Chervenak, FA, McCullough LB, "What is Obstetric Ethics?", *Clinical Obstetrics and Gynecology* 1992, 35 (4): 709-719; Laurence B. McCullough, Frank A. Chervenak. *Ethics in Obstetrics and Gynecology* (New York: Oxford University Press, 1994) pp. 98.
[124] Chervenak and McCullough (1994) call these "social-role" interests, pp. 102.

so under particular circumstances has obligations towards it. They also make an important distinction between viable and non-viable foetuses. A viable foetus, defined as a foetus in the gestational period where it "can survive ex utero with full technological support, as required to supplement immature or impaired anatomy and physiology..."[125], is capable or receiving medical interventions that will uphold its interests whereas the pre-viable foetus cannot reliably receive such health-care interventions. This distinction is relevant because it separates the foetuses that can be treated by medical interventions from those who cannot and therefore separates those foetuses towards whom we have beneficence based obligations from those we do not.[126]

McCullough and Chervenak define a patient as an individual who (a) is presented to the physician (b) in order to receive treatments that can be expected to uphold the interests of that individual.[127] A viable foetus, by definition, fulfills the second condition, while the pre-viable foetus does not. Of course, the gestating foetus cannot be presented alone, and so is dependent on the pregnant woman to physically provide access to the foetus. The pregnant woman, as the foetus's moral fiduciary has a beneficence-based obligation to present the foetus given that its interests can be promoted with

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[125] *Ibid.*, pp. 103.
[126] There is no obligation to do the impossible. We cannot be obliged to save the life of a terminally ill foetus.
[127] Chervenak and McCullough, 1994, pp. 104.

treatment. When the pregnant woman is obliged to provide access to the viable foetus in order for it to receive medical treatment, the foetus is a patient[128].

Although this conception does not specifically refer to the argument for potentiality, many elements of the position are based on the presumed existence and desirability of a future moral condition for the foetus. Underlying the argument is the assumption that attaining independent moral status is a fundamental human good in which a foetus has a stake.[129] This foetal interest then creates the beneficence-based obligation to use medical interventions to promote this end, and further generates fiduciary obligations for the mother. This is not clearly an argument from potentiality because this valued future moral condition creates a present interest held in some sense by the foetus. It is the present interest that the remainder of the argument responds to.

The foetus in the context of elective caesarean delivery is viable and healthy. As such, it can reasonably be assumed that this foetus can effectively be treated by medical intervention if necessary, fulfilling McCullough and Chervenak's second condition for patient-hood. If the woman carrying this

[128] A non-viable foetus is not a patient because it fails to fulfill the second condition. This kind of foetus and can only attain independent moral status through the autonomous decision by the mother (recall that it cannot receive medical treatments therefore we have no beneficence based obligation to provide this). In this case, the pregnant woman can confer the status of being a patient to her foetus. Similarly, she can decide not to confer this status, or decide to revoke conferred status as long as the foetus is previable.

[129] Chervenak and McCullough., 1994, pp. 102.

foetus fulfills her fiduciary responsibility to make this foetus available for any necessary intervention, then the first condition has also been met, and the foetus can be identified as a patient. Having identified the foetus as a patient, the physician is required to act beneficently towards the foetus to ensure that treatment entails a greater balance of medical benefits over medical harms. As indicated by the discussion of medical evidence outlined above, there is no evidence to suggest that elective caesarean delivery presents greater risks to the foetus than vaginal birth. Under this conception of the foetus, it seems that delivery using this method is consistent with obligations of beneficence towards the foetal patient and so falls within the bounds of permissible treatment.

2.3.5 Foetus as a person

The final position I will discuss is one which takes the view that, from conception, the foetus is morally speaking, a person, and therefore carries the full compliment of rights equal to other persons (importantly, normal adults including the pregnant carrier). In his work, Patrick Lee first presents a number of biological arguments to show that the foetus is a distinct, complete, and whole human being.[130] Unlike Warren, who draws a distinction between the genetic and moral humanity, Lee uses genetic humanity with a version of the argument for potentiality to contend that

[130] Patrick Lee, *Abortion & Unborn Human Life* (Washington DC: The Catholic University of America Press, 1996).

genetic humanity and moral humanity are one and the same.[131] Lee defines 'person' as someone who is, *or has the capacity to be* an "intelligent and free subject"[132]. On Lee's account, zygotes, embryos, and foetuses possess this capacity because they will eventually be able to think and will, given a little time to develop. The argument concludes then, that all human beings, including foetuses and embryos, are persons.

The status of the foetus does not rely on any conferred rights, as the foetus is said to merit this moral standing in virtue of the intrinsic nature of it being a whole human being. It has a moral claim based on its present capacity (in a qualified sense) which is connected to its future abilities to exercise this capacity. In this sense, Lee's account seems to rely on the argument for potentiality. Similar to McCullough and Chervenak's indirect reliance on potentiality, it is probably more accurate to say that the foetus is said to have these capacities based on an expectation of certain skills developing after birth, but it is based on the present character of the foetus that it merits the title of person. In other words, on Lee's account we ought to treat the foetus a certain way because it is a person now. This is distinct from Engelhardt's account where the foetus could merit certain treatment because it will be a person later.

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[131] *Ibid.*, pp. 3-5.
[132] *Ibid.*, pp. 5.

In the context of the abortion debate, one implication of foetal personhood is that to abort a foetus is to kill an innocent human person and is therefore morally wrong. Far from discussing the morality of killing another human person, elective caesarean delivery raises questions regarding the morality of choosing to expose a person to risks other than the ones they would normally face as is the case for a foetus who could reasonably expect to face the risks inherent to labour and delivery, but could instead be exposed to the risks posed by caesarean delivery. An analogy here may be helpful. Suppose, to carry on Judith Jarvis Thompson's well-known analogy[133], you have come to terms with the fact that you somehow have ended up in bed with the unconscious violinist and have managed to keep yourself occupied for the past eight and a half months while he, in virtue of being attached to your kidneys, slowly recovers from his illness. You have become aware that there are two available methods for detaching the violinist from your kidneys, both of which entail differing risks to you and the violinist. The physician assures you that although the kinds of risks entailed in each method are different for the violinist, they are of more or less equal in

[133] Judith Thomson, "A Defense of Abortion," *Philosophy and Public Affairs*, 1, No. 1 (Fall 1971), 47 – 66. This analogy is used to defend the position that abortion is permissible even if the foetus has full rights. She asks us to imagine that we wake up one day and find ourselves hooked up to an unconscious, ailing violinist. We have been kidnapped because we have a unique blood type that is required to save his life. To keep him alive we must stay in this bed with him for nine months while he makes use of our kidneys. After nine months he will be unplugged and be cured, provided we have stayed there the entire time. If we decide to leave, he will surely die. Jarvis argues that if it is outrageous that we have an obligation to keep this man alive, then it is equally outrageous that pregnant women have an obligation to keep their foetuses alive.

probability and severity. Most people would agree then, that you are free to decide on a method based on other considerations if it, in effect, doesn't make a difference to the violinist either way.

The analogy implies that, if it is true that elective caesarean delivery presents more or less equal risk as compared to vaginal birth, it is morally permissible to choose to deliver a foetus this way, even if it is, morally speaking, a person and has full and equal moral claim. Again, there is no evidence to suggest that elective caesarean delivery presents greater risks to the foetus than vaginal birth, so under this conception of the foetus, it seems that it is morally acceptable.

2.4 Conclusion

I have shown that elective caesarean delivery is morally compatible with five general moral conceptions of the foetus. Even with positions that one would expect to be most problematic – foetus as a person, contributing to value, having dignity – the nature of the procedure is such that dignity, value, and human rights can remain uncompromised. With the issue of the moral status of the foetus aside, I can, in my next chapter, explore whether it is plausible to conceptualize the morality of elective caesarean delivery as one might, cosmetic surgery.

Chapter 3

A Comparison with Cosmetic Surgery

3.1 Introduction

Having examined the moral status of the foetus, we can explore whether it is reasonable to think of elective caesarean delivery as we do a cosmetic surgery procedure. I use 'cosmetic' to refer to procedures that aim to improve the appearance of healthy individuals, for example, liposuction, collagen injection, breast enhancement, and face-lifts. Plastic surgery I take to encompass both cosmetic and reconstructive surgeries. Although the boundary between these two is blurry, the former refers generally to surgeries that enhance bodies that are healthy and fall within a range or physical normalcy and the latter refers to the reconstruction of physiological structures deformed through accident, disease, or malformed in fetal development.

As a practice, cosmetic surgery is one of a group of procedures that presents risks of medical harm and negative side effects but presents little or

no opportunity for medical benefit. Individuals who choose these procedures usually do so for reasons that are unrelated to medicine. Other such procedures include contraception, sterilization, abortion, all of which have been more or less accepted as legitimate activities within medicine[134,135]. These procedures are similar with one another because they address conditions that are not traditionally thought of as maladies or disease. Vasectomies, for example, do not treat a medical condition because fertility isn't a disease. Insofar as the presence of disease increases the potential for medical benefit, the procedure carries risks of medical harm, but can provide little, if any benefit of this sort. Physicians who perform such procedures, it could be argued, are violating the principle of beneficence because they are placing their patients in harm's way without the chance of deriving clinical benefit. Although there are many practical reasons for why these procedures fall under the jurisdiction of physicians, for those like Pellegrino and Thomasma who see the primary purpose of medical practice as the treatment of disease, there seem to be few if any ethical justifications for this practice. Yet vasectomies are accepted both within the medical community and in society,

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[134] Beauchamp, TL, 'The Origins, Goals, and Core Commitments of *The Belmont Report* and *Principles of Biomedical Ethics*, printed in Jennifer K. Walter and Eran P. Klein, eds. *The Story of Bioethics* (Washington, DC: Georgetown University Press, 2003), pp. 33.

[135] Brody H, Miller FG, The Internal Morality of Medicine: Explication and Application to Managed Care, *Journal of Medicine and Philosophy* 1998, 23(4): 384-410.

and are a service that is expected to be made available by the appropriate clinician.

I choose to use cosmetic surgery as a representative of this category of procedure for two reasons. First, as mentioned in Chapter 1, cosmetic surgery is raised specifically (and promptly rejected) in the literature on elective caesarean sections as a possible model for evaluating elective caesarean delivery. In the interest of following up on the current literature, it is the natural choice. Second, cosmetic surgery is perhaps the most extreme of these kinds of treatments. The procedure is obtained almost exclusively through patient initiative, the risks entailed can be incredibly severe, and the reasons for undergoing this kind of procedure are often very far removed from anything related to medical value. These features, combined with the fact that cosmetic surgery remains as part of medical practice make it a particularly striking example for discussion. For the purposes of the comparison with elective caesarean delivery, I'll refer specifically to surgical chest enhancements (breast or pectoral implants) as a representative example of cosmetic surgery procedures.

I begin by outlining the similarities between elective caesarean delivery and chest enhancements to support the premise that it is at least reasonable that they receive similar moral evaluations. Next, I engage in a thought experiment that applies the argument form of the dominant critique

of elective caesarean delivery to chest enhancement procedures. The differences between the moral course of action in providing chest enhancement prescribed by this evaluation and the way the procedure is approached in reality highlights the disparity between the dominant evaluation of elective caesarean and that of cosmetic surgery procedures, which, given their relevant similarities, brings into question the adequacy of one or both of these analyses. This exercise also sets the foundation for the argument (to be discussed in Chapter 4) that the dominantly advocated approach to elective caesareans is the less appropriate of the two.

If the first sections of this chapter succeed in suggesting that there is an unjustified difference between our moral evaluation of elective caesarean delivery and that of chest enhancement it isn't necessarily clear how this should be resolved. The two obvious solutions require that we either re-evaluate our approach to chest enhancements and procedures like it, or reconsider the current (dominant) evaluation of elective caesarean delivery. Criticisms of cosmetic surgery as a practice could garner support for the alternative that we ought to re-evaluate our approach to chest enhancement. The next section discusses an example of such a criticism suggested by Brody, Miller, and Chung.

Following, I discuss some possible disanalogies between chest enhancement (and cosmetic surgery in general) and elective caesarean

delivery. The chapter concludes with a return to the moral theory first introduced in Chapter 1, where I, setting the foundations for Chapter 4, begin to explore the theoretical foundations of this disparity in approaches.

3.2 Comparison of Elective Caesarean Delivery and Chest Enhancement

Chest enhancement and elective caesarean delivery share a number of morally relevant features. First, neither operation is medically necessary. That is, there is no existing ailment or condition within the body that requires intervention. Further, and as a result, there is little potential for medical benefit, and as with any major surgery, there is potential for serious medical harms. As such, to perform either a chest enhancement or an elective caesarean section is to violate the principle of beneficence. Both surgeries could be chosen by, and performed on healthy competent individuals who seek the operation for largely personal reasons.

The most obvious difference between elective caesarean delivery and chest enhancement (aside from considerations of the foetus which were dealt with in the previous chapter) is the latter has been defended in the literature[136] and, on some significant level, been granted public and professional acceptance while elective caesarean sections are being

[136] Dahl, M, "Liberty, Anyone?"[comment], *Archives of Dermatology* 1998, 134(10): 1293-1294; Gross, EA, "Cosmetic Surgery for Aging is Not Inherently Immoral" [comment], *Archives of Dermatology* 1998, 134(10): 1294.

condemned. The application of the form of moral evaluation of elective caesarean delivery to chest enhancements is a useful thought experiment because it will likely demonstrate that the recommendations for moral behaviour in the context of providing, say, pectoral implants will be different from currently accepted practice. Unless some ethically relevant difference between the two procedures can be pointed to, this incongruence between their evaluations seems unjustified, raising questions whether a different evaluation of one or the other would be more appropriate.

3.3 Applying the Argument Form of the Dominant Moral Evaluations of elective Caesarean Delivery to Chest Enhancement Procedures

Recall that the dominant evaluation of elective caesarean delivery revolves around two questions: Ought physicians to offer elective caesarean delivery to pregnant women as a delivery option? And if not, ought they to comply when faced with a request for one? The first question refers to decisions made at the professional level to establish professional standards regarding appropriate procedures to offer for particular medical conditions. The second question refers to an exchange between a physician and a patient who has interests, values, beliefs which the physician (according to the principle of respect for autonomy) has a duty to respect and assumes that the

professional organizations have *not* decided to include elective caesarean delivery within the ranges of possible procedures discussed with the patient.

In response to the first question, the dominant critique concludes that it is unethical to offer elective caesarean delivery because to do so would violate the principle of beneficence[137]. In response to the second question, when faced with a request some authors strongly encourage physicians to pressure women against pursuing the procedure. They recommend persuading the woman to change her mind[138], or at the very least asking her to reconsider her decision[139].

The same two questions can also be asked about a procedure that gives people larger breasts or more pronounced pectoral muscles. Ought chest enhancements to be offered to patients in general, and if not, what ought a physician to do if faced with a request?[140] In response to the first question, it would seem that an evaluation using the argument form of the dominant critique of elective caesarean delivery would conclude that it is equally impermissible to offer chest implants of any kind because performing these kinds of procedures also entails a violation of obligations of beneficence. As is the case with the requests for elective caesarean delivery,

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[137] Chapter 1.
[138] Paterson-Brown et al., 1998, pp. 464.
[139] Sharma et al., 2004, pp. 407; Minkoff et al., 2004, pp. 390.
[140] Note: the fact that at the professional level it is decided not to initiated discussion (or offer) a particular procedures as a matter of course to appropriate patients does not necessarily imply that the procedure itself is altogether ethically impermissible. Although they may decide not to do so on moral grounds, it may be morally appropriate for that procedure to be performed upon request.

the patient requesting chest enhancement is actively choosing a procedure that presents risks of medical harm and no medical benefits so the dominant critique should similarly advocate that the patient be persuaded to change his mind and seek treatments or activities that can meet his goals in some other way.

These conclusions deviate from what many take to be acceptable moral practice in cosmetic surgery. In North America, many kinds of cosmetic surgery procedures (including chest implants) are available to those willing and able to pay for them, and certainly cosmetic surgeons do not, as a matter of course, actively discourage their patients from undergoing procedures.

This analysis is worth repeating in terms of McCullough and Chervenak's interests framework. The dominant critique of elective caesarean delivery concludes that physicians ought not to offer the procedure because it cannot meet the patient's social-role interests. When faced with a request - something that is reasonably said to arise from a patient's subjective or deliberative interests – McCullough and Chervenak say that physicians ought to ask the woman to reconsider her desires and persuade the woman to change her mind, because, again, the procedure does not clearly meet her social-role interests. When the underlying argument form described here is applied to an evaluation of breast implants, for example, the conclusion

would most likely be that, out of consideration for the patient's social-role interests as a patient, such procedures ought not to be offered. More strikingly, when an individual solicits breast implant surgery, the surgeon ought, again out of primary consideration for her social-role interests, to persuade the woman against the procedure.

The similarities and lack of ethically significant differences between elective caesarean delivery and chest enhancement procedures suggests that the basis of our moral evaluations of these two procedures as well as their results – the elements of the procedure recognized as morally significant, the recommended courses of action etc. – should also be similar. Either we ought to condemn breast implant operations on the same or similar grounds as is being done with elective caesareans, or we should consider recasting our evaluations of elective caesareans to align them more closely with our current approach to such cosmetic procedures. If there were robust criticisms showing that our current acceptance of cosmetic surgery is mistaken, then arguments to have elective caesarean delivery treated as we do cosmetic surgery would be absurd. The more reasonable solution in this case would be to resolve this incongruence with the former strategy. The next section discusses a possible criticism.

3.4 Cosmetic Surgery and the Goals of Medicine

Miller, Brody, and Chung argue that cosmetic surgery lies, at best, on the fringes of appropriate medical practice because it fails to fulfill the goals of medicine (outlined in Chapter 1)[141]. Moral standards and principles, such as duties to beneficent action, direct behaviour and restrict the means by which these goals can be reached. Procedures and interventions tend to be accepted within the core domain of medicine to the extent that they meet one or more of these goals. Amputating a gangrenous arm to prevent further infection is accepted as a legitimate procedure in medicine, while trepanation – non-therapeutic skull drilling – is not. Cosmetic surgery generally fails to fulfill the goals of medicine because having a flat chest, large nose, droopy eyelids, or less than perky rear end is generally not considered a malady, and so interventions to change these features do not entail "care and cure" as intended by medicine. As a result, cosmetic surgery can, at best be described morally as a peripheral medical practice.

But, recalling their *internal morality of medicine* described in Chapter 1, Brody et al.'s approach fundamentally assumes the primacy of beneficence over other principles. To put it in terms of the interests-based framework, the goals of medicine and moral evaluations that rely on them are concerned only

[141] Miller, FG, Brody, H, Chung, KC, Cosmetic Surgery and the Internal Morality of Medicine, *Cambridge Quarterly of Healthcare Ethics* 2000, 9, 353-364; When they take into account the advertising practices of the industry they seriously question the ethical permissibility of the practice.

with patient's social-role interests. Although a range of principles (including those of respect for autonomy) ostensibly play a role in this moral schema, they act to restrict and moderate the goals themselves and do not expand or otherwise alter the content of these goals. As a result, this approach bears a similarity to the kinds of analyses in medical ethics promoted by Pellegrino, Thomasma, and those who contribute to the dominant position on elective caesarean delivery.

The goals of medicine can be helpful in giving a conceptual account of 'medicine' and they, to some extent can be used as a heuristic for identifying what can be adopted as legitimate practice for physicians. However, used in the latter capacity, the goals of medicine relegate some normally accepted medical procedures to the moral periphery. These constitute a category of practices that are considered morally permissible by physicians, but have a borderline status regarding whether or not they fulfill the goals of medicine and the general expectations of the moral community.[142] Miller, et al. argue that professional integrity depends on "the commitment to norms of the internal morality of medicine and medical practice"[143]. Morally peripheral procedures are apt to conflict with these norms because they tend to fail to or only weakly fulfill the goals of medicine and entail a violation of professional duty. The acceptance of morally peripheral procedures, then, comes at a cost

[142] Brody, H, Miller, FG, 1998, pp. 390.
[143] Miller et al., 2000, pp. 360.

to the moral integrity of the medical profession so should be avoided if possible. Interestingly, their conclusion about the morality of cosmetic surgery does not reflect their argument's implications that cosmetic surgery and like procedures simply do not constitute medical practice. Instead they choose to accept cosmetic surgery as a part of medical practice because to reject it would be "unlikely to have practical effect" [144]. They comment further that to reject cosmetic surgery on these grounds entails a rejection of procedures that are widely accepted in the field – a consequence they would rather avoid.[145]

Elective caesarean delivery fails to fulfill the goals of medicine because pregnancy isn't a disease. Miller's argument implies that we ought to reject elective caesarean delivery because to accept another procedure on the moral periphery entails a further erosion of the ethical standards of the medical institution. Although it isn't intentional, Miller et al.'s analysis supports my position that the moral evaluations of elective caesarean delivery and cosmetic surgery should be similar if not the same. Rather than argue that both procedures ought to be similarly accepted, however, their implied conclusion is that both ought to be rejected.

So far, cosmetic surgery has been discussed as a representative of a category of procedures that present medical harm to the patient without also

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[144] Miller et al., 2000, pp. 362.
[145] *Ibid.*

providing potential medical benefit. A moral evaluation based on the goals of medicine would similarly deny the moral acceptability of vasectomies, tubal ligations, prescription of oral contraceptives, and non–medically indicated abortions[146]. While Miller and friends are content to maintain their 'goals of medicine' approach to ethical dilemmas in medicine in spite of this implication, I see no need to, largely because other analyses are available that do not have this consequence. Rather than raising questions about the appropriateness of the practice of cosmetic surgery specifically, Miller et al's argument succeeds only in supporting my arguments for bringing into question the adequacy of their approach and their underlying assumptions. In Chapter 4, I'll explore more closely an alternative to this position – one which takes into account the patients' subjective and deliberative interests.

3.5 How Chest Enhancements and Elective Caesarean Delivery might be Disanalogous

Some might object to my argument by claiming that elective caesarean delivery and surgical chest enhancements are not sufficiently similar to warrant similar moral approaches. Here I discuss two possible disanalogies that relate to the notions of 'offering' and role of advertising, and considerations of justice and distribution of resources.

[146] Abortions undertaken to prevent serious health problems or death for the mother fulfill the goals of medicine. Here I refer to those that are pursued only to terminate the pregnancy.

3.5.1 Offering, Advertising, and Common Knowledge of Medicine

There are two senses in which the procedures and practices surrounding chest enhancements and elective caesarean delivery differ. The first deals with differences in nature of the initial *source* of information that motivates a patient to seeking a particular procedure. In Chapter 1, I limit the notion of 'offering' a procedure to the very specific act of including it on a predetermined list of possible procedures to treat a particular complaint or ailment as part of the informed consent process. Under this conception, information about a particular procedure is provided by the physician to a patient in the context of a medical consultation. While this could describe the way a discussion about elective caesarean delivery is initiated, it makes little sense to speak of the availability of breast implants in this way because the conditions that tend to motivate individuals to seek this kind of procedure - generally related to a dissatisfaction with one's appearance - are highly subjective and are unlikely to compose the type of complaint a patient would present to their general practitioners. Although there *is* documentation of cosmetic procedures being offered in a similar fashion[147], it is not the standard route by which individuals are introduced to the idea of cosmetic surgery.

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[147] D. Cepanec and B. Payne, "Chapter Six: 'Old Bags' Under the Knife, Facial Cosmetic Surgery Among women", in *Women's Bodies/Women's Lives, Health, Well-being, and Body Image*, ed. B. Miedema, J.M. Stoppard, V. Anderson , (Sumach Press, 2000) pp.121.

Cosmetic surgery generally is not pursued because it is offered in the above sense, but instead is solicited out of awareness by the individual of information related to its availability and potential 'benefits'. Most people in North America know about 'nose-jobs' and 'implants' long before a health care professional talks to them about it directly. Each of us has general knowledge about a range of topics, including medicine, the content of which varies dramatically from person to person based on exposure, experience, and individual receptivity. Still, there is a shared knowledge of sorts among most people which includes, for most adult Westerners at least, a common awareness of the existence of and possibilities presented by cosmetic surgery. The existence and content of this common knowledge about medical procedures and cosmetic surgery in particular cannot be said to entail 'offering' these kinds of procedures in the sense that I have defined the term. However, this knowledge *does* contribute to whether or not an individual seeks this kind of services because, in short, one cannot go looking for something they don't know is there.

Whether information about a procedure is obtained through the process of physician 'offering' or through accessing and reflecting on the contents of one's general body of knowledge, the impacts of each are similar because both information sources contribute to a patient's education about health matters which can importantly affect their choices and change the

character of the interaction between patient and physician. A clear difference is that by being offered, a procedure receives a professional endorsement speaking to its safety and effectiveness.

It *isn't* clear that the difference in the *sources* of information about chest enhancements and elective caesarean delivery is significant to this project though. The relevant similarities between the two procedures involve the degree of medical risk presented, the potential for medical benefit, the health and competency of the patient, and the nature of reasons that motivate seeking such a procedure. One might argue that the quality of information coming directly from a consulting physician would generally be higher and therefore contribute more effectively to the patient's informed consent. This qualitative difference could be a problem if it were possible to make use of information derived from one's general body of knowledge, without having to consult a physician. As it is, with information related to prescription drugs and medical procedures patients cannot do much more than take it to their physician, providing both patient and physician and opportunity to engage in an informed exchange allowing the patient to obtain a similar quality of information to exchanges that are initiated by a physician offering a procedure. In any case, there is no necessary or inherent quality of information as a result of coming from one source over another. Physicians can conceivably give out poor or unhelpful information (intentionally or no),

and information available from this greater body of knowledge can be highly accurate and useful. *Where* one first hears about a procedure itself seems insignificant and so cannot act as reasonable evidence to suggest that elective caesarean delivery and pectoral implants deserve different forms of moral evaluation.

The second difference between elective caesarean delivery and surgical chest enhancement relates to the *content* and *consequences* of the dispensation of information related to these procedures. The cosmetic surgery industry relies heavily advertising: the paid promotion of their services and products. Critics have argued that the *content* of this information provided a by cosmetic surgeons in the form of advertising often overstates the possibility of positive results while understating or omitting altogether information about health risks and the potential for negative outcomes[148]. Even if we ignore or remediate this questionable practice, these commentators further argue that advertising creates, as an undesirable *consequence*, an unfounded 'need' among individuals who otherwise may not have considered surgery. This, they argue, amounts to the promotion of unnecessary surgery for healthy individuals - a practice that is tantamount to

[148] Miller et al., 2000, pp. 360.

the deliberate creation of disease in order to expand practices and overall earnings[149].

Even if there were a strong criticism against the advertising practices of the cosmetic surgery industry this criticism does not affect the moral scaffold of chest enhancements as a medical procedure where patient's subjective or deliberative interests are given primary considerations its availability and delivery. In other words, advertising in any form (although possibly guilty of affecting autonomy in other ways that merit discussion) does not cause the practice of cosmetic surgery to fail as an example of a medical practice that prioritizes autonomy over considerations of beneficence. If is fully conceivable that the industry could proceed within this moral framework without engaging in advertising.

Similar concerns have been brought most recently to the pharmaceutical industry regarding, in addition to the *content* and *consequences,* the *motivations* behind their dissemination of medical information via direct-to-consumer (DTC) advertising practices [150]. Opponents to DTC advertising of pharmaceuticals argue that the practice is fundamentally underhanded because its primary *motivation* is financial gain,

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[149] *Ibid.*

[150] Mintzes, B, Blurring the boundaries: new trends in drug promotion, Amsterdam: HAI-Europe, 1998, (Accessed September 1st, 2002, at http://www.haiweb.org/pubs/blurring/blurring.intro.html.).

not education[151]. This is reflected in the patterns of *content* in DTC advertising where pharmaceuticals related to sexual functioning and mild mood disorders - conditions that are easily self-diagnosed - attract the majority of advertising money. Concerns similar to those raised with cosmetic surgery regarding the *consequence* of creating false need are also expressed as a particular vulnerability of certain sorts of conditions. In regards to cosmetic surgery Stephen Latham comments, "Demand for fuller lips can be created by advertising, while only cancer can create demand for oncological services."[152] Similarly, through suggestive pharmaceutical advertising, general moodiness and normal periods of low energy can be self-diagnosed as depression and chronic fatigue, creating a market for anxiety medication where there wasn't one before.

Proponents of this practice argue that DTC advertising promotes patient autonomy and generates "better informed consumers" which can lead to better care as a result of a better diagnosis, better matching of therapy to the desires of the patient, and as a result of the latter, increased patient compliance.[153] Pat Kelly (of Pfizer) writes, "since the U.S. Food and Drug Administration (FDA) relaxed its restrictions on such communications in 1997, Americans have seen what amounts to on of the largest and most

[151] Mykitiuk, 2003, pp.29. [need full reference]
[152] Latham, SR, "Ethics in the Marketing of Medical Services", *The Mount Sinai Journal of Medicine* 2004, Vol. 71, No. 4, 243-250.
[153] *Ibid.* Interestingly in this publication and others on this topic "patient" and "consumer" are used interchangeably.

successful public health campaigns in history, in the form of prescription drug advertisements. DTC communications serve as a catalyst for people to take a hands-on interest in their own health care..."[154] In general, it is said that DTC advertising goes some way to increase public knowledge of medical information and contributes to individual awareness and empowerment in actively promoting and maintaining personal health.

This discussion may have been a little misleading so far because it implies that there is a relevant distinction to be made between the notions of 'offering' and 'advertising'. While it may be tempting to point out the *source* of information as a relevant difference between advertising and other forms of information dissemination, the previous discussion suggests that there is no necessary or inherent standard of quality of information tied to one source of medical information over another. Differences in *content* and *motivation* also seem to fail to provide a distinction. Pharmaceutical companies' claims that DTC advertising is pursuit in the interest of patient education blurs an already fuzzy line between advertising, informing, and offering, making it difficult to distinguish what has traditionally been identified as advertising from other forms of public dissemination of information.

Whether or not we believe that DTC advertising is primarily intended to educate the consumer, or that it succeeds at promoting patient autonomy,

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[154] Kelly, P, "Perspective: DTC Advertising's Benefits Far Outweigh Its Imperfections" *Health Affairs* 2004, Jan-June, pg.W246.

this mode of communication *does* contribute to the body of medical information that is available to patients. Realistically, the mode of dissemination and control over content of medical information is no longer the sole jurisdiction of the medical profession; professional organizations have little power to monitor or police the manipulation of this kind of information beyond its membership. This reality emphasizes the significance of the distinction made in discussions of elective caesarean delivery between offering and responding to patient requests. Professional organizations can exert some control over public awareness of elective caesarean delivery by choosing not to offer the procedure. Still, they are forced to consider how to respond to requests, because information about elective caesarean delivery is available to their patients even if they do not provide it.

To respond to the original objection regarding advertising as a problematic disanalogy, if the advertising and modes of offering cosmetic surgery cannot be distinguished from other forms of public dissemination of medical information including information about elective caesarean delivery then these features of the practice of cosmetic surgery do not constitute a significant difference and so do no present a problem for this analysis.

3.5.2 *Distributive Justice and Allocation of Resources*

A second notable difference between chest enhancement procedures and elective caesarean delivery relates to issues of distributive justice. While the costs of chest enhancements are covered by the individual patient and are performed in private clinics, elective caesarean deliveries could conceivably be publicly funded. If this were the case, they would likely occur in public hospitals, so endorsing them would constitute a drain on already strained public health care resources. While this difference is unlikely to be convincing as a reason why elective caesarean delivery and cosmetic surgery do *not* merit similar form of moral evaluation it might constitute a reason beyond considerations of beneficence, autonomy, and individual interests why we ought to carefully consider the availability of this procedure.

Issues of justice play out at the individual and societal levels, and in the context of medical ethics, generally concern treatment of patients and in doing so, the distribution of medical resources. Much like the other principles, there is no single principle of justice so the character of rules and guides that are ultimately derived from it will depend on separate moral and political commitments.[155] Although described in a variety of ways, regardless of the overarching theory of just distribution, obligations of justice at the

[155]Tom L. Beauchamp, "The Origins, Goals, and Core Commitments of The Belmont Report and Principles of Biomedical Ethics" in The Story of Bioethics, eds. Jennifer K. Walker, Eran P. Klein (Washington DC: Georgetown University Press, 2003) pp. 26.

individual level minimally require that patients be treated fairly. Tom Beauchamp describes just treatment as that which is given "according to what is fair, due, or owed."[156] Justice minimally requires that, under whatever system of distribution is being used, individuals are not discriminated against, that is, denied treatment or given substandard treatment, for reasons that are unrelated to their medical condition be it race, gender, religion, or sexual orientation.[157]

At the societal level, justice is most concerned with allocation of a resource that is finite and, in many cases, scarce. Various norms of distribution can determine what is "owed" or "due" to the individual reflecting particular values and priorities as members of a health care system. Whatever the accepted distribution, justice, at least in the Canadian health care system, requires that individuals have "equitable access" to health care resources while ensuring that these resources are being used wisely.[158] Justice also requires that health care providers be aware that a decision to devote resources in the form of technology, operating room space, expertise, and time, to a particular patient may well result in a reduction of available

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[156] *Ibid.*
[157] ACOG, Ethical Foundations, Part I. Code of Professional Ethics of the American College of Obstetricians and Gynecologists, 2004.
[158] Canadian Medical Association, *Responsibilities to Society #43, #44,* CMA Code of Ethics, 2004.

resources for another.[159] Most of our intuitions about justice further require that these resources are given out with certain medical priorities in mind. Procedures deemed medically necessary ought to be given some kind of systemic priority over elective procedures, while procedures that are deemed entirely unnecessary are given little if any consideration at all.[160]

It is very reasonable that there is some concern that accepting caesareans on demand within the socialized Canadian system would pose an additional and unnecessary drain on a system already at its limits. The press release of the Society of Obstetrics and Gynaecology of Canada (SOGC) expresses this concern: "At a time where Canadian men and women are waiting weeks if not months for proper treatment of serious conditions such as cancer, it would be irresponsible to promote an elective procedure that would require the increased use of limited resources."[161]

A 2003 US study comparing costs between elective caesarean and vaginal delivery found that a vaginal delivery without the use of oxytocin or epidural anesthesia costs 15-20% less than an elective caesarean birth.[162] For women having their first child, the use of oxytocin nullifies any difference in

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[159] Laurence B. McCullough, James W. Jones, Baruch A. Brody. Surgical Ethics (New York: Oxford University Press, 1998) pp. 8.
[160] I do not mean that there is absolute priority given, otherwise less serious problems would never be attended to. Note also that elective doesn't mean unnecessary. Procedures such as gall bladder removal are both medically necessary and considered elective.
[161] Society of Obstetricians and Gynaecologists of Canada (SOGC) Advisory, C-Sections on Demand – SOGC's position, Wednesday March 10, 2004.
[162] Bost, Brent W, Cesarean delivery on demand: What will it cost? *American Journal of Obstetrics and Gynecology* 2003, 188: 1418-23.

cost, and the use of epidural in addition increases the costs to 10% above those projected for an elective caesarean delivery. As one might expect, the cost of a caesarean delivery following a failed attempt at vaginal delivery costs much more than an elective caesarean delivery alone. The study concludes that on average, an attempt at vaginal birth costs only 0.2% less per patient than an elective caesarean birth. It is unclear how, with differences in drug costs and procedures, the results of this study might translate into the Canadian context. Still, the results might be a surprise to some. The resource issue still has not been addressed fully though. Beyond dollars and cents, issues of operating room availability, surgical staff, and other non-liquid resources are still a consideration.

While some theorists argue that considerations of justice (a duty-based principle) impose limits on obligations of beneficence at the social level[163], it is worth exploring how considerations of justice limit individual autonomy. Engelhardt notes that "one cannot contain maintain freedom in the choice of health care services while containing the costs of healthcare."[164] Time and space preclude me from addressing this topic much further, and it is possible that we need not explore this line of reasoning at all.

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[163] Robert M. Veatch, "Revisiting *A Theory of Medical Ethics:* Main themes and Anticipated Changes" in *The Story of Bioethics,* eds. Jennifer K. Walker, Eran P. Klein (Washington DC: Georgetown Unversity Press, 2003) pp. 76.
[164] H. Tristam Engelhardt, 1986, pp. 337.

Issues of operating room space cannot be resolved as easily. One could always suggest that we remove such concerns by stipulating that elective caesarean delivery be offered through private clinics in a similar fashion to cosmetic surgery. This would not only prevent the needless consumption of facilities, and money in public hospitals, but additionally remove the costs to the system of the vaginal delivery had the woman not decided to have an elective caesarean delivery. This suggestion, of course raises a long list of other moral and practical problems that I don't intend to address in this work, but it is, I believe, a worthwhile consideration that deserves attention from either myself or others in the future.

3.6 Cosmetic Surgery and Social Philosophy

The social aspects of cosmetic surgery similarly raise important concerns that lie outside the original foundations of this analysis in this project, but constitute other reasons why we might want to avoid using cosmetic surgery as a moral exemplar. Purely theoretical analyses such as the one offered here and in the literature can fail to turn up problems inherent to cosmetic surgery. The abstract nature of these analyses necessitates the exclusion of certain practical aspects isolating institutions from their social context. Other commentators – generally those working in feminist philosophy or women's studies – acknowledge this context and, in their work

criticize cosmetic surgery based on its observed and projected social consequences.

Returning to a familiar, although in this case slightly different division, social issues brought to the fore by cosmetic surgery are relevant at one of two levels – the level of the individual, and the level of society. At the societal level these issues are related to cultural images of beauty and youth, the nature of social relationships, and to some extent, the role of the medical profession. At an individual level, notions of self-identity, agency, and choice are of primary importance. Critics such as Rosemarie Gillespie[165] and Diane Cepanec and Barbara Payne[166] focus on the societal issues. They argue that cosmetic surgery represents a reinforcement of gender inequality by adding yet another oppressive layer on women by increasing the demands on their finances, time, and body to meet a particular standard of beauty. Unattainable physical ideals are repeatedly represented in the media where women are bombarded with images of beauty that most can never attain, perpetuating the ongoing consumption of products and services designed to help create a "desirable"[167] or at least acceptable appearance. The availability and promotion of cosmetic surgery is a particularly extreme example of this form of media because this range of services is most costly not only

[165] Gillespie R, "Women the Body and Brand Extension in Medicine: Cosmetic Surgery and the Paradox of Choice", *Women & Health*, 1996, 24(4): 69-85.
[166] D. Cepanec and B. Payne, 2002, pp. 121.
[167] *Ibid.*, pp. 122.

financially, but in other ways as well. Compared to most other beauty services, cosmetic surgery procedures require a time investment for operation and recovery, as well as a willingness to endure the risks of surgery as well as the risk of potential long term health effects of a particular procedure.

Gillespie, Cepanec, and Payne acknowledge the consequences of this social environment – that individuals (and women in particular) who meet these standards of beauty are more liked and trusted, more likely to be perceived as sexually desirable, more likely to establish lucrative employment and more likely to achieve success in their careers. At the individual level, some argue that improving one's appearance with cosmetic surgery is the ultimate exercise of one's autonomous agency[168]. Gillespie writes, "Through reinventing and investing in their bodies, individual women may raise their social value through creating an appearance that conforms to dominant images of beauty."[169] It is then, completely rational at the individual level, given the conditions in which women find themselves, for a woman to choose to undergo cosmetic surgery procedures. But, as Gillespie points out[170], such a decision is made within the greater social fabric, and so cannot be evaluated in isolation. The increased social acceptance that can be gained through surgery is acceptance only within a culture that values

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[168] See K. Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (London: Routledge, 1995).
[169] Gillespie, 1996, pp. 81.
[170] *Ibid.*, pp. 79.

women in very restricted ways. But the decision to have cosmetic surgery amounts to an acceptance of the system itself. Despite the social gains afforded by cosmetic surgery, choosing to undergo surgery is a choice to "reproduce the social institutions that oppress them."[171]

This analysis of cosmetic surgery would presumably contribute to an objection that because cosmetic surgery is inappropriate as an exemplar for autonomy-based moral evaluations because it reproduces negative social institutions. This argument would require consideration in my analysis if it could be shown that the social context of cosmetic surgery has caused or maintains the heavy emphasis of autonomy over beneficence in the moral framework used in the industry. This connection between the sociology of cosmetic surgery and its underlying moral scaffolding has not been made. As it stands, that cosmetic surgery may have negative social consequences for some has little relevance to the balance of moral principles implied in its practice.

3.7 Accounting for the Disparity – Underlying Moral Assumptions

The similarities outlined in previous sections suggest that cosmetic surgery and elective caesarean delivery could reasonably be evaluated in similar fashions. That the argument form of the dominant critique applied to

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[171] *Ibid.*, pp. 82.

cosmetic surgery yields results that are so different from actual practice in industry that questions are raised about the way these two practices are considered.

This difference might initially be explained within the principlist framework by the difference in the prioritization of principles of respect for autonomy and beneficence discussed in Chapter 1. Cosmetic surgery is ethically acceptable, in one sense, because it proceeds with nearly complete emphasis on patient autonomy with almost no consideration of beneficence playing into surgeons' ethical deliberations.

To explain it in terms of McCullough and Chervenak's framework, cosmetic surgery generally proceeds out of concern for the patient's subjective interests and/or deliberative interests with consideration of their social-role interests limited to the physician's obligations to perform the requested procedures with appropriate care and skill, in appropriate surgical environments, in a way that maximizes patient health and minimizes exposure to harm. With this emphasis on autonomy, all that is morally required for cosmetic surgery is the patient's self-motivated desire for the procedure and their full understanding of all the risks.

So the question now is *why* are there these differing prioritizations in our moral evaluations. What are the underlying moral justifications for emphasizing one principle over another? Is the nature of these justifications

such that these prioritizations are absolute? Ought they to be? Chapter 4 addresses these questions relating to the impacts of these underlying assumptions more fully.

3.8 Conclusion

This chapter introduced a category of procedures that are similar because they are primarily sought by patient initiative and fail to offer medical benefit while presenting medical harm. Cosmetic surgery is a paradigmatic example of this kind medical intervention because it portrays the extremes of all of these features. It is generally not discussed without first being solicited by the patient, it can present very extreme risks, and it can be sought for the kinds of subjective or deliberative interests that are most clearly unrelated to medical values. Yet it, and the other procedures already mentioned, have gained acceptance within the medical institution in North America. A comparison between elective caesarean delivery and chest enhancements underscored their relevant similarities, bringing into question the great disparity in evaluation demonstrated by the application of the argument form of the dominant evaluation of elective caesarean section to chest enhancement procedures.

An exploration of Brody et al.'s criticism of cosmetic surgery revealed a larger problem with their approach than with the aspects of cosmetic

surgery they brought into question. Although there are some obvious differences between elective caesarean delivery and cosmetic surgeries in general, the differences relating to procedure availability, advertising, and justice, are not relevant to theoretical foundations of the practice and so do not affect this analysis.

An analysis using McCullough and Chervenak's interests-based framework highlights the difference between the current approaches to these procedures. The dominant commentary of elective caesarean delivery assumes the primacy of patients' social-role interests, and the acceptance of cosmetic surgery and procedures like it derives from an assumption of the primacy of subjective and deliberative interests. As outlined in this framework, social-role interests relate to physicians' beneficence-based obligations, where these subjective and deliberative interests are acknowledged through principles of respect for autonomy. This chapter served to introduce and support the major theme of Chapter 4 which highlights the division between Pellegrino, Thomasma, Miller, Brody, Chung, and those who promote the dominant evaluation of elective caesarean delivery (which includes McCullough and Chervenak) who defend and endorse the primacy of beneficence, (the prioritization of patients' social-role interests), and Veatch and Engelhardt who defend and endorse an approach to moral evaluations that assumes the primacy of respect for autonomy.

Chapter 4

Theoretical Support for Beneficence and Respect for Autonomy

4.1 Introduction

In Chapter 3, I drew an analogy between the dominant moral evaluations of surgical chest enhancements and elective caesarean sections to raise questions regarding whether or not the differences between these moral evaluations can be justified. In *this* chapter, I return to the bioethical theory introduced in Chapter 1 to determine the extent to which the differences between these moral evaluations can be explained by underlying philosophical arguments such as those put forward by Pellegrino, Thomasma, Miller, Brody, Veatch, and Engelhardt. My discussion of medical ethics theory in Chapter 1 suggests that the conventional analysis of elective caesarean sections is *not* the only reasonable one available to us. The similarities highlighted by the analogy drawn between elective caesarean

delivery and surgical chest enhancement suggest that there is a viable alternative method of moral evaluation for elective caesarean delivery. While strong theoretical arguments for the primacy of beneficence might support the beneficence-dominated evaluations of elective caesarean delivery seen in the literature to date, there are, it seems, equally well-supported arguments for an approach that focuses instead on respect for autonomy.

Rather than arguing for the absolute prioritization of one position over the other in this project, I introduce a third option put forward by theorists Tom Beauchamp and James Childress[172], which rejects the possibility of the universal primacy of one principle over another altogether, and suggests instead that the ordering of these principles depends on the specific features of the medical procedure or case at hand. These features are broadly construed and, where patient interests are relevant, are not obviously limited those that are internally or externally identifiable. On this account, the details and context of a particular case carry greater *moral* weight than underlying moral commitments, and so dictate the structure of the moral evaluation. With this suggestion in mind, I take initial steps to explore whether, given the nature of elective caesareans, one might argue that respect for autonomy might be *more* relevant than considerations of beneficence.

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[172] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 5th Ed., (New York: Oxford University press 2001).

4.2 Theory in Medical Ethics – Autonomy and Beneficence

Edmund Pellegrino and David Thomasma argue that duties of beneficence rightly eclipse those of respect for autonomy because such is the nature of the relationship between patient and physician. The telos of this relationship is to achieve what is technically and morally good for the patient, which is, in turn, achieved through a "right and good healing and helping act"[173]. Although they acknowledge some role for individual autonomy in their schema, it is constrained by overarching obligations of beneficence. Howard Brody and Franklin Miller maintain a similar position. They propose a conceptual framework, the *internal morality of medicine*, that evaluates moral practice in medicine by measuring the degree to which a decision or action fulfills the goals of medicine, which, as they describe them are based fundamentally in beneficence –oriented concerns of healing and curing. On Miller and Brody's account, principles of respect for autonomy cannot add to the goals of medicine, but can only limit the means by which these goals can be reached, suggesting a lexical priority of principles of beneficence over those of respect for autonomy.

Robert Veatch and Tristam Engelhardt reject the primacy of beneficence and argue in favour of giving primary consideration to principles of respect for autonomy. Using a variation on contract theory, Veatch shows

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[173] Edmund D. Pellegrino, David C. Thomasma. *For the Patient's Good* (New York: Oxford University Press, 1988).

that there is more to medical ethics than medical risks and benefits. "Duty-based" principles, like those of justice and respect for autonomy, are of fundamental importance, he argues, because they necessarily contribute to the "right-making" feature of any moral prescription, independent of consequences. "Duty-based" principles are lexically ordered ahead of the "consequentialist" ones – those of beneficence and non-maleficence. [174] Veatch's lexical order is not justified on the basis of patient good. In fact it may not contribute to patient good in every case. But the fundamental "right-making" character of autonomy makes it the first priority in ethical decision making in medicine.[175]

Engelhardt similarly identifies the principle of respect for autonomy as the overriding moral principle.[176] He rejects moral realism, and instead identifies socio-cultural norms as the source of morality. A secular humanist, he also rejects the notion of religiously derived morality. He therefore argues that the basis of moral authority (in effect, of any kind of moral code at all) is the existence of mutual respect and self-determination among individuals. In other words, respect for autonomy is the foundation of morality; it is the fundamental principle in all moral deliberations and cannot be set aside in favour of some other principle.

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[174] Robert M. Veatch, 2003, pp. 75.
[175] *Ibid.*, pp. 81.
[176] H. Tristam Engelhardt Jr., 1986, pp. 80, 82.

While Pellegrino and Thomasma do not specifically discuss elective caesarean delivery, and neither do McCullough and Chervenak or others who contribute to the dominant critique of elective caesarean delivery make specific reference to Pellegrino and Thomasma, the two camps appear to share a basic philosophical commitment to the primacy of beneficence. To put this in the terms of McCullough and Chervenak's moral framework, we might characterize this position as asserting that medicine has (and ought to have) a primary responsibility to patients' social-role interests over subjective or deliberative interests. Veatch and Engelhardt, on the other hand, might be said to be committed to the ultimate importance of the recognition of internally identifiable interests and the interests themselves - those that, unlike social-role interests, are *not* determined by happening to have chosen a particular career, fallen ill, or had children, but those interests that represent a more complete aspect of an individual's range of self determination.

It should be apparent by now that both at the professional level, and at the level of the individual, the dominant commentary on elective caesarean delivery presupposes the primacy of considerations of beneficence (relating only to social-role interests) where the entailing good is narrowly defined in terms of medical goods. The argument implies that medical risk, a direct consideration for evaluating the beneficence of an action, is, and ought to be, the deciding factor behind the moral acceptance or rejection of any particular

procedure. The assumption is that if conditions of beneficence cannot be met, the procedure in question is morally impermissible.

The prioritization of concern for social-role interests (those that medicine is, by definition, capable of identifying and meeting) over subjective or deliberative interests might seem reasonable to some. After all, most of us visit a physician with the expectation that she will treat our ailment to the best of her experience and ability with a sincere concern for our health. But this prioritization cannot account for a series of procedures in medicine that are provided, not out of concern for patients' social-role interests, but in response to those interests that are internally identified. As outlined previously, such procedures include cosmetic surgery, sterilization, and abortions. These medical interventions cannot purport to have primary concern for considerations of beneficence, because to perform them is necessarily to expose individuals who do not display malady or disease to risks of medical harms, in order to meet ends that are unrelated to medicine. The are, and *can only be,* morally justified on the grounds of the moral primacy of respect for autonomy – because competent fully informed adults can knowingly incur medical risks for non-medical benefits deemed by them to be worthwhile. That elective caesarean delivery has so far been evaluated assuming the moral primacy of beneficence and not that or respect for

autonomy, then, seems arbitrary. There is good reason to reevaluate elective caesarean delivery with primary consideration given to respect for persons.

4.3 Moral Evaluation of Elective Caesarean Delivery Assuming the Primacy of Respect for Autonomy

A prioritization of respect for autonomy can justify current practice in the cosmetic surgery industry, while a presumption of the absolute primacy of beneficence justifies the dominant position taken on elective caesarean delivery. I do not intend to argue for the primacy of one principle over another here, but, taking Veatch and Engelhardt's arguments for the primacy of autonomy seriously, I develop a rough account of a moral evaluation of elective caesarean delivery that places a greater emphasis on considerations of respect for autonomy. Whether we accept that individual autonomy is a necessary condition for moral agency in secular society, as Engelhardt suggests, or that principles of autonomy necessarily contribute to "right-making" characteristics of moral actions, there seem to be good arguments for allowing it to be taken more into account.

In contrast to the much described beneficence-based view that rejects elective caesarean delivery on the basis of medical risk, an autonomy-based view takes the patient's desires as primarily important and accepts that an individual can incur medical risks presented by elective cesarean delivery

with little or no benefit to her health as long as she is fully informed. This account expands the role of autonomy beyond the confines of the informed consent procedure, and puts it into a more decisive role in establishing treatment options. Conceptualizing the provision of elective caesarean delivery at the individual physician-patient level with assumptions of the primacy of autonomy seems fairly straightforward. Rather than mediating the procedure via risk/benefits analyses and considerations of harm, patient choice would be the deciding factor. As required by principles of respect for autonomy, the physician would be obliged to inform the patient of all the risks and potential harms presented by the procedure; however, the degree to which this information influenced whether or not the patient received this treatment would be decided by the patient herself, not the physician.

Certainly, some might object to this account because it seems to imply an *absolute* primacy of respect for autonomy over other considerations. Howard Minkoff worries that giving respect for autonomy priority risks turning physicians into technicians which "assumes that, as a lay person, each patient is capable of identifying medically reasonable alternatives and that physicians are obligated to carry out patients' requests simply because they are the patients' requests." [177] This result, he argues, in the devaluation

[177] Minkoff et al., 2004, pp. 390.

of clinical expertise and judgment which contributes to the deterioration of the integrity of the medical profession.

This thesis takes a more modest approach however, suggesting only that a primacy of respect for autonomy in the *evaluation of elective caesarean delivery* is at least as justified as its application to evaluations of cosmetic surgery procedures – a claim that does not necessarily entail an argument for the primacy of respect for autonomy in all cases. My position allows for the possibility that the contextual features of *other* types of requests or procedures may justify the prioritization of considerations of beneficence. Even, in cases where respect for autonomy is decisive, the physician's judgment and experience could be valuable to the patient's decision making process, and would certainly still be necessary for obtaining proper informed consent. So even in cases where respect for autonomy is given greater priority of beneficence-based concerns, clinical expertise and experience is integral so professional integrity is not at stake.

Having established that approaches that prioritize respect for autonomy are at least as reasonable as those that prioritize beneficence, I return to the question posed at the end of Chapter 3, which asks whether or not such prioritizations *ought to* be absolute. I wonder, in the interest of having a coherency and consistency among our moral evaluations in medical ethics, whether an absolute priority of respect for autonomy or beneficence is

the best route. In Chapter 3 I propose two ways to bring the differing moral evaluations of elective caesarean delivery and surgical chest enhancement into alignment: either we re-evaluate our moral position on cosmetic surgery, or we take a more autonomy-based approach to elective caesarean delivery. But it seems that both of these options are problematic. An approach to medical ethics that absolutely prioritizes respect for autonomy creates problems for the integrity of the medical profession, while a beneficence approach rules out a group of procedures that have been accepted as morally legitimate medical practice. A framework that allows for a more plural approach may more effectively capture the diversity of moral concerns in medicine.

In the next section, I turn then, to a moral framework put forward by Tom Beauchamp and James Childress which rejects absolute prioritization of principles. I also explore whether this account can provide support for the position that a prioritization of respect for autonomy in evaluation elective caesarean delivery is *more* justified than the emphasis on beneficence in current evaluations.

4.4 Third option – Beauchamp and Childress

So far I have discussed two competing theories: those that argue for the primacy of respect for autonomy in our moral evaluations in medicine,

and those that argue for the respect for beneficence. My suggestion that an autonomy-based approach to elective caesarean delivery is as justifiable as a beneficence-based one implies a rejection of an absolutist position on the matter. Tom Beauchamp and James Childress defend this position in their view that neither beneficence nor respect for autonomy can be prioritized unequivocally over the other. Well known for their contribution to the biomedical ethics literature with their work, *Principles of Biomedical Ethics*[178], they are credited as the first theorists to present a comprehensive, and now widely accepted, four-principle theory of medical ethics. The four principles of this approach are 1) Respect for Autonomy, 2) Nonmaleficence, 3) Beneficence, and 4) Justice. These constitute part of a larger moral framework put forth by Beauchamp and Childress which also includes rights, virtues and moral ideas.[179] While the latter three elements compose an important part of the framework, these authors argue that principles "provide the most general and comprehensive norms"[180]. Their account is often mischaracterized as giving moral primacy to considerations of autonomy over the other three principles. James Childress corrects this mischaracterization, "PBE [*Principles of Biomedical Ethics*] does not put primary weight on autonomy or *respect for* autonomy... It may often trump,

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[178] Tom Beauchamp, James Childress, *Principles of Biomedical Ethics* (New York: Oxford University press, 1978, 1983, 1989, 1994, 2001).
[179] Tom Beauchamp and James Childress, 2001, pp. 13.
[180] *Ibid.*

but it does not have a priori superiority over, other principles."[181] Beauchamp and Childress reject any form of absolute prioritization or lexical ordering of principles and instead counsel agents to balance conflicting principles as best they can.[182]

This third account rejects the view that one ought to maintain a consistent priority of one moral principal over another in ethical analyses and allows instead for the decisiveness of one principal in one case and another in a second case. This position comes out of Beauchamp and Childress's rejection of foundational moral theories in favour of those that take the *common morality* to be the source of our moral practice and policy. On their account, this common morality is composed of the basic norms of moral life; these norms are shared by morally scrupulous individuals and "bind all persons in all places"[183]. While there is one universal common morality, there is more than one *theory* of common morality, that is, more than one theory that turns to the content of the common morality, rather than fundamental moral theories as a starting point[184]. Beauchamp and Childress's framework, also a *common morality* theory, holds that ethical theories (e.g. Kantianism,

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[181] James F. Childress, "*Principles of Biomedical Ethics:* Reflections on a Work in Progress" in *The Story of Bioethics,* eds. Jennifer K. Walker, Eran P. Klein (Washington DC: Georgetown University Press, 2003) pp.53.

[182] They provide some guidelines for doing this with minimal intuition and subjective interference. See James F. Childress, 2003, pp. 60 for a brief listing. See Tom Beauchamp and James Childress, 2001, for more detailed discussion.

[183] *Ibid.*, pp. 3.

[184] *Ibid.*, pp. 403.

Utilitarianism etc.) that produces prescriptions for moral behaviour that conflict with pretheoretic commonsense moral judgments are rightly questioned. So far, they argue, no moral theory has succeeded in providing constructive analyses and policy partly because there is little consensus even among those who support a particular theory on how to specify and apply the commitments of the theory to specific issues. Even if this were possible, Beauchamp and Childress argue, the justifications and norms of behaviour tied to these theories are simply more vulnerable to contest than the norms in common morality. Common morality, then, evaluates the content of moral theory, not the other way around.

According to Beauchamp and Childress, approaches to ethics that seek justification by an appealing to abstract moral theory – so called, "Top-down" approaches – fail to acknowledge the subjectivity in moral decision making, particularly in those cases where principles cannot be clearly applied. They write:

> Even if we have our facts straight, the choice of facts and the choice of rules that we deem relevant will generate a judgment that is incompatible with another choice of facts and rules. Selecting the right set of facts and bringing the right set of rules to bear on these facts are

not reducible either to a deductive form of judgment or to the resources of a general ethical theory[185]

Moral theories that argue for the primacy of one principle over another like those presented by Pellegrino and Thomasma, or Veatch and Engelhardt similarly fail to account for these choices, so do not hold much authority or currency according to Beauchamp and Childress.

Their account explicitly acknowledges the contextual details of a given medical situation as ethically relevant to the overall prioritization of principles in the moral evaluation. In other words, they say there are *facts* of the matter that ought to be taken into account, in spite of rational philosophical argumentation about moral theory. These contextual details then determine the balance of principles appropriate for the particular medical situation. Theirs is not entirely a "Bottom-up" model of justification– one where particular cases and judgments support moral conclusions independently of established norms, however. Rather, they advocate a model referred to as "reflective equilibrium" or "coherence theory" where judgments, through Rawlsian reflective equilibrium, are "match[ed]", "prune[d]", and "adjust[ed]" to bring them in line with the premises of general moral commitments.[186] This reflective equilibrium can take into account "the strengths and weaknesses of all plausible moral

[185] *Ibid.*, pp. 387.
[186] *Ibid.*, pp. 348.

judgments, principles, relevant background theories", "a variety of kinds and levels of legitimate beliefs as possible, including hard test cases in experience", in addition to "beliefs about particular cases, about rules and principles, about virtue and character, about consequentialist and nonconsequentialist forms of justification, about the moral standing of fetuses and animals, about the role of moral sentiments and so forth."[187] On Beauchamp and Childress's account, moral conclusions are justified to the degree that they cohere with existing norms and considered judgments. A prescription for action that maximally coheres with current moral norms and considered judgments is then, the most justified.[188] The appropriate prioritization and emphasis of principles and moral rules in a particular moral contest is similarly be justified. Of course, acknowledge Beauchamp and Childress, coherence with a particular set of moral norms alone cannot justify a conclusion because the set itself could be morally deficient.[189] Coherentism, then, is closely connected with the generally accepted moral norms in common morality. They write: "This [...] points to the importance of starting with considered judgments that are settled moral convictions and then casting the net more broadly in specifying, generalizing, and revising those convictions."[190]

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[187] *Ibid.*, pp. 399.
[188] *Ibid.*, pp. 404.
[189] *Ibid.*, pp. 400.
[190] *Ibid.*

Beauchamp and Childress acknowledge that it is theoretically possible to keep rules or principles that are incoherent with one another, but only if parameters are set to limit the scope of each principle, and if methods for balancing principles are made explicit. The process of prioritizing or assigning emphases to individual principles is vulnerable to the biases and subjectivity of the individual evaluator. They outline the following six conditions for minimizing subjectivity in this process:

1. Better reasons can be offered to act on the overriding norm than on the infringed norm (e.g. if persons have a right, their interests generally deserve a special place when balancing those interests against the interests of persons who have no comparable right.)
2. The moral objective justifying the infringement must have a reliable prospect of achievement.
3. The infringement is necessary in that no morally preferable alternative actions can be substituted.
4. The infringement selected must be the least possible infringement, commensurate with achieving the primary goal of the action.
5. The agent must seek to minimize any negative effects of the infringement.
6. The agent must act impartially in regard to all affected parties; that is, the agent's decision must not be influenced by morally irrelevant information about any party.[191]

These requirements for balancing principles, combined with the coherence theory of justification outlined earlier constitute the tools in Beauchamp and Childress's framework to determine whether a prioritization of autonomy over considerations of beneficence is more justified in the

[191] *Ibid.*, pp. 19-20.

evaluation of elective caesarean delivery. I will apply these criteria to the two prioritizations of principles outlined in this work to determine which prioritization is most justified for the evaluation of elective caesarean delivery. Criteria (5) and (6) seem to relate to the agent's behaviour *after* having applied a particular balance, so is irrelevant to this debate. For this reason I will focus on criteria (1)-(4).

In reference to (1) supporters of beneficence would argue that beneficence ought to override considerations for respect for autonomy because this approach reduces the medical uncertainty and possibility of bodily harm presented to the patient by elective caesarean delivery. Further, these supporters might argue, allowing for medical procedures that present these unnecessary health risks for healthy individuals contributes to the erosion of the integrity of the medical profession. The desire to avoid this consequence presents another reason to prioritize beneficence over respect for autonomy.

That the individual who is most affected by this deliberation - the pregnant woman – has the greatest chance to have her wishes met with this prioritization seems to provide a strong reason to prioritize *autonomy* over beneficence. Although she may be choosing to make herself susceptible to medical risk, she is doing so willingly, (ideally) having calculated these factors into her decision-making procedure.

Condition (2) requires that there be a reasonable chance that the objectives of a particular prioritization of principles be fulfilled. A prioritization of beneficence over autonomy would likely succeed in maintaining the integrity of the profession insofar as it relies on this kind of prioritization. It seems less clear that a prioritization of beneficence would necessarily result in the minimization of medical harm to the patient. A vaginal delivery entails a certain amount of risk, and having a woman deliver in this fashion by discouraging her not to undergo an elective caesarean does not guarantee that she will be suffer less harm overall than she would have by undergoing an elective caesarean delivery. It seems clearer that there is a greater chance of achieving one's moral objectives by prioritizing respect for autonomy over beneficence. Acknowledging the patient's choice as the decisive factor achieves this goal regardless of the consequences of this choice.

Criteria (3) and (4) relate closely a notion of the "primary goal of the action". I suggest that the primary goal in the context of elective caesarean delivery is to safely deliver a healthy infant in a way that is morally or emotionally satisfactory to the mother, first, and the physician second. While the prioritization of beneficence succeeds at promoting the health of mother and infant and satisfies a physician who takes beneficence to be important to her profession, this prioritization seems less able to ensure that

the pregnant mother interests are met completely. A prioritization of autonomy *in specific reference to elective caesarean delivery and its entailing medical risks* seems likely to meet all elements of this primary goal except those of the beneficence-oriented physician. Given that the women's interests come before the physician's, a prioritization of autonomy seems more likely to fulfill the "primary goal of action" than a prioritization of principles of beneficence.

Coherence related justifications comprise the second tool in Beauchamp and Childress's framework for determining an appropriate prioritization of principles in our evaluations of elective caesarean delivery. Although I will not attempt to do a complete analysis of the coherence of the evaluations stemming from particular prioritizations, my earlier work (in Chapters 1 and 3) suggests that a prioritization of autonomy would produce an evaluation of elective caesarean delivery that is coherent with the evaluations of procedures to which it is relevantly similar. In terms of McCullough and Chervenak's interest framework, Beauchamp and Childress's account allows for coherency in our evaluation because it can encompass patient's internally and externally identifiable interests.

Having just briefly looked at four of the six criteria for balancing principles along with considerations of coherence, Beauchamp and Childress's framework suggests that a prioritization of respect for autonomy

might be *more* justified than a prioritization of beneficence. Certainly, this framework has its critics, and there is much room to question, starting with the way in which it is implemented above, but I hope to have at least plausibly suggested that first, this framework is potentially fruitful to an analysis of prioritization of principles, and second, that initial and brief attempts to spell this out suggest that respect for autonomy is, under this account, more appropriately given primacy. Undoubtedly this analysis could be completed with greater care and depth; however I reserve this task for future work.

4.5 Pellegrino and Thomasma help out

Perhaps with some unwitting acknowledgement of the importance of context in the moral evaluations, Pellegrino and Thomasma give two general arguments stemming from descriptive ethics (rather than their physician-patient relationship derived ontology) in support of ranking beneficence over respect for autonomy. First, they argue that the condition of being ill can and does to some degree affect patient competence[192]. Although this is a matter of degrees and so likely varies from illness to illness, they argue that we cannot discount the impairing nature of "being sick". To put the full weight of decision making on such a patient, they argue, is to do a great

[192] Pellegrino and Thomasma, 1988, pp.18.

disservice to that patient. Their second argument, perhaps related to the first, is that patients often do not want to shoulder the full responsibility of autonomy, and frequently request that the physician make decisions for them.[193]

While there may some empirical basis for the second claim[194], it seems that in light of certain contextual features of the procedure, neither of these arguments apply to elective caesarean delivery. In response to the first argument, the patient seeking an elective caesarean, a healthy pregnant woman, is not "sick" and so reasonably retains the decision-making capacity of any other agent. Currently, physicians do not routinely initiate discussion about cesarean section delivery unless there is some emergent medical reason for the procedure. Even if a physician did raise elective caesarean delivery as an option, it seems implausible that, in response to the second argument, that all pregnant women would want the physician to make the decision regarding whether or not to go through with it. There may be some who would be more comfortable with the physician making the decision, but there are those who would rather decide for themselves. The second claim cannot account for this latter group. These arguments fail to be relevant to the other

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[193] Pellegrino and Thomasma, 1988, pp. 17.

[194] This observation can be supported by empirical evidence. See: Carl E. Schneider, *The Practice of Autonomy, Patients, Doctors, and Medical Decisions* (New York: Oxford University Press, 1998).

procedures outlined throughout this project – abortion etc. – for the same reasons.

To return to themes in Chapter 3, both elective caesarean delivery and chest enhancements represent cases where the patients are *not* asking the physicians to make the decision for them. Similarly, neither patient is suffering from illness or disease when making the decision so arguments that cite the decreased competence of patients due to disease, depression, agitation, etc. do no hold either. That these arguments for the prioritization of beneficence apply neither to elective caesarean delivery nor cosmetic surgery, helpfully elaborates on the analogy I draw between the two in Chapter 3.

4.6 Conclusion

This chapter shows that the difference in respective approaches to surgical chest enhancement and elective caesarean delivery can be explained by their differing underlying philosophical commitments. The moral acceptance of surgical chest enhancements is consistent with prioritizations of respect for autonomy, while the dominant evaluation of elective caesarean delivery is similarly consistent with commitments to the primacy of beneficence. The discussion in Chapter 3, which suggests that an autonomy-based approach to elective caesarean delivery is at least reasonable, brings

into question the robustness of the dominant evaluation of elective caesarean delivery when it suggests that there is an equally justified yet opposite set of theoretical commitments (an emphasis on autonomy over beneficence) available for the analysis.

Beauchamp and Childress's moral framework provides support for the premise that we can adopt an autonomy-based account of elective caesarean delivery without casting aside the use of beneficence-based approaches in other cases where it is justified. Their criteria for balancing principles combined with their coherence theory of justification constitute conceptual tools for evaluating the conventional prioritization of beneficence considerations in evaluations of elective caesarean delivery. A cursory analysis using these tools suggests that an approach to this mode of delivery with primacy of respect for autonomy is more justified than a prioritization of beneficence. A short discussion of Pellegrino and Thomasma's practical arguments for the prioritization of beneficence shows that they too fail when applied to elective caesarean delivery and similar procedures. This further supports the position that an evaluation of elective caesarean delivery is as, if not more justified than the approach demonstrated by the dominant evaluation of elective caesarean delivery to date.

Conclusion

Elective caesarean delivery is one of many issues in medical ethics and principlism is one of many evaluative frameworks available to resolve it – certainly the framework used by the most vocal commentators on elective caesarean delivery. I have suggested that within this principlist framework, fundamental theoretical commitments and assumptions play an important role in determining our interpretation of the framework and, as a result, our conclusions.

The dominant evaluation of elective caesarean delivery concludes that there are no beneficence-based obligations to provide or in most cases, acquiesce to a request for elective caesarean delivery.[195] The empirical evidence is too thin for the medical outcomes, and therefore, for the medical value of this procedure to be known. The concept of 'beneficence' in this approach is (not coincidentally) the same as that introduced in McCullough and Chervenak's interests framework for bioethics where it is informed mostly by medical risk/benefit analysis. In this approach to moral

[195] See Chapter 1.

evaluation, the degree of beneficence of a procedure *cannot* be known without conclusive empirical evidence. Theorists in support of the dominant evaluation argue that there isn't sufficient empirical evidence to indicate that elective caesarean delivery is either safer, or less safe than vaginal birth, for either the pregnant woman or the foetus, so minimally there is at least no *obligation* to perform this procedure and, given the possibility that it might be unsafe, it may be unethical to do so.

Most who comment on this issue argue that our duties of beneficence towards the *foetus,* specifically, ought to be taken seriously. Though there are those who might concede that the autonomous pregnant woman might justify incurring risk to herself, there is general agreement that not even she can justifiably incur risks on behalf of the foetus. In Chapter 2, I addressed these claims and consider elective caesarean delivery using several moral conceptions of the foetus. I argued that even when ascribing a full complement of rights to the developing foetus, the procedure cannot be rejected on the grounds of beneficence-based obligations because existing evidence suggests that there is, in fact, no increased risk to the foetus, and perhaps even *less* risk compared to vaginal delivery. Given that foetal considerations do not weigh in on either side of the argument, they are set aside.

In Chapter 3 I questioned this data- dependent approach to medical morality by bringing in the issue of cosmetic surgery. I drew an analogy between surgical chest enhancements and elective caesarean delivery to show that the two share some morally relevant features, the most significant of which being that both entail a violation of the principle of beneficence. Yet cosmetic surgery has been generally accepted as a medical practice while elective caesarean delivery, at least in the literature, is being condemned. I concluded that, *prima facie*, the difference in the evaluations of these two procedures appears unjustified. Surgical chest enhancement is an example of an autonomy-driven procedure and is morally accepted as such, while elective caesarean delivery is held to the standard of risk/beneficence analyses and medical value, where physician's obligations of beneficence are held to be most important, and considerations of patient autonomy remain under-emphasized in the analysis.

Chapter 4 revealed that the conventional analyses of both elective caesarean deliveries and surgical chest enhancements *are* justified by their underlying moral commitments which establish the priority of one principle over another; elective caesarean delivery's analyses is justified by presumptions of primacy of beneficence, while surgical chest enhancements are justified by presumptions of primacy of respect for autonomy. I introduced Beauchamp and Childress's moral framework in support of my

position that, without advocating for the absolute primacy of either, approaches to elective caesarean delivery that prioritize considerations of respect for autonomy are as reasonable as those that prioritize beneficence. Beauchamp and Childress reject the absolute prioritization of any one principle in favour of evaluations that rely on a variety of sorts of relevant moral and non-moral information including contextual details about a particular case or procedure. An introduction and brief analysis of elective caesarean delivery using their criteria for balancing principles and coherence theory of justification suggested that an autonomy based approach to elective caesarean might be *more* justified than the beneficence based approach taken in the current literature.

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